HEALTH NEW ENGLAND

MEMBER HANDBOOK FOR THE

COMMONWEALTH OF MASSACHUSETTS

GROUP INSURANCE COMMISSION

EFFECTIVE JULY 1, 2004

EMPLOYEES
AND
RETIREES WITHOUT MEDICARE

Interpreter and Translation Services

HNE will provide Members, upon request, interpreter and translation services related to administrative procedures. If you need such services, just tell a Member Services Representative when you call. Then during your call, we will use the AT&T Language Line to reach an interpreter who will help us to answer your questions.

(Arabic)

ستؤمِّن HNE للأعضاء مترجما فوريا وخدمات ترجمة تتعلق بالإجراءات الإدارية وذلك بناء على طلب هؤلاء الأعضاء. فإذا كنت بحاجة إلى خدمات ترجمة، فما عليك إلا أن تقوم بإعلام ممثل خدمات الأعضاء بذلك عندما تجري مكالمة هاتفية، فنقوم، أثناء مكالمتك الهاتفية هذه، بالاستعانة بشركة Language Line Services للوصول إلى مترجم فوري يساعدنا على الإجابة على أسئلتك.

(Cambodian: Khmer)

HNE នឹងផ្តល់ឲ្យសមាជិកនូវតាមសំណូមពររបស់គេនូវកិច្ចបំរើខាងបកប្រែភាសានិងលើក្រដាសដែលជាប់ទាក់ទងនិងជំណើរការខារដ្ឋបាល ។ បើអ្នកត្រូវការកិច្ចបំរើខាងការបកប្រែ គ្រាន់តែក្រាប់អ្នកតំណាងខាងបំរើសមាជិក នៅពេលដែលអ្នកទូរស័ព្ទទៅគេ ។ បន្ទាប់មក នៅក្នុងពេលដែលអ្នកទូរស័ព្ទនោះ យើងនឹងប្រើកិច្ចបំរើខាងភាសាតាមទូរស័ព្ទ (Language Line Services) បន្តភ្ជាប់ទៅអ្នកបកប្រែ ដែលនឹងជួយយើងដើម្បីឆ្លើយនិងសំនួរ របស់អ្នក ។

(Cantonese)

HNE 將應請求爲會員提供 與行政程序相關的傳譯及翻譯服務。如果您需要翻譯服務，只需於來電時告知會員服務代表。然後，通話時，我們將使用 Language Line Services 聯絡一名傳譯員，該名傳譯員將協助我們回答您的問題。

(French)

HNE fournira aux membres des services d'interprétation et de traduction pour les procédures administratives sur demande. Si vous avez besoin de traduction, dites-le au représentant du Service des membres quand vous appelez. Au cours de votre appel, nous utiliserons alors Language Line Services afin de contacter un interprète qui nous aidera à répondre à vos questions.

(Greek)

Η εταιρία HNE θα παρέχει στα μέλη της, κατόπιν αιτήσεώς τους, υπηρεσίες διερμηνείας και μετάφρασης που σχετίζονται με τις διοικητικές διαδικασίες. Αν χρειάζεστε μεταφραστικές υπηρεσίες, απλώς ενημερώστε τον Αντιπρόσωπο Εξυπηρέτησης Μελών στο τηλεφώνημά σας. Στη συνέχεια, κατά τη διάρκεια της κλήσης σας, με τη χρήση των υπηρεσιών της εταιρίας Language Line Services θα επικοινωνήσουμε με έναν διερμηνέα που θα μας βοηθήσει να απαντήσουμε στις ερωτήσεις σας.

(Haitian)

Kon manmb yo mande, HNE dwe bay manmb yo entèprèt ak sèvis tradiksyon pou nenpòt bagay sou fason administrasyon an fè zafè li. Si ou bezwen sèvis tradiksyon, kareman rele Reprezantan Sèvis Manmb yo lè ou rele. Epi, padan apèl ou-an, nap sèvi ak Language Line Services pou nou jwenn yon entèprèt pou ede nou reponn keksyon ou yo.

(Italian)

HNE renderà disponibili ai membri, su richiesta, servizi di interpretariato e traduzione in merito ai procedimenti amministrativi. Qualora necessitiate di tali servizi, communicate le vostre esigenze al momento della vostra chiamata ad un rappresentante del servizio membri. In questo modo, durante la chiamata, utilizzeremo il servizio Language Line Services per contattare un interprete che ci assisterà nel rispondere alle vostre domande.

(Laotian)

HNE ຈະຕ້ອງໃຫ້ບໍຣິການແກ່ສມາຊິກ, ພາຍຫຼັງມີການຂໍ, ຜ້ແປພາສາປາກເປົ່າແລະຂຽນ ໃຫ້ການບໍຣິການທີ່ກ່ຽວ ຂ້ອງກັບຣະບຽບການຂຶ້ງເປັນບໍລິຫານ. ຖ້າທ່ານຕ້ອງການໆບໍຣິການແປພາສາ, ພຽງແຕ່ບອກກັບຜ້ຕາງໜ້າຝ່າຍບໍຣິ ການສມາຊິກ ເວລາທ່ານໂທໄປ. ແລ້ວໃນເວລາທີ່ທ່ານໂທຢ່ນັ້ນ, ພວກເຮົາຈະໃຊ້ສາຍບໍຣິການດ້ານແປພາສາ (Language Line Services) ໃຫ້ຕິດຕໍ່ ເອົ້ามายพาสาผู้มีๅ ซึ่งจะช่วยพวกเราตอบคำถามของท่าน.

(Mandarin)

應要求，HNE 會提供會員有關行政程序方面口譯員與翻譯服務。如您須要翻譯服務，打電話來時請告知會員服務代表。然後，在與您通話中，我們會透過 Language Line Services 與口譯員連線，由他協助我們回答您的問題。

(Portuguese)

A HNE deverá fornecer aos seus associados, conforme requisição, os serviços de intérpretes e tradutores relacionados aos procedimentos administrativos. Caso necessite de serviços de tradução, mencione ao Representante dos Serviços aos Associados na ocasião da sua ligação. Assim, durante a sua chamada telefônica, utilizaremos “Language Line Services” para contatar um intérprete o qual irá nos ajudar a responder suas perguntas.

(Russian)

HNE предоставит членам, по их просьбе, услуги устного и письменного перевода, связанные с административными процедурами. Если Вам нужны услуги переводчика, скажите об этом представителю бюро обслуживания клиентов, когда Вы звоните. После этого, во время Вашего звонка, мы воспользуемся услугами Language Line Services (Бюро переводческих услуг по телефону), чтобы связаться с переводчиком, который поможет нам ответить на Ваши вопросы.

(Spanish)

HNE suministrará a los socios que así lo soliciten servicios de intérprete y traducción relacionados con los procedimientos administrativos. Si necesita servicios de traducción, solamente comuníqueselo al representante del servicio de atención a socios cuando llame por teléfono. Luego, durante su llamada, utilizaremos Language Line Services para contactarnos con el intérprete que nos ayudará a responder a sus preguntas.

TABLE OF CONTENTS

MEMBER HANDBOOK

SECTION 1 – INTRODUCTION

HOW TO USE THIS MEMBER HANDBOOK

This Member Handbook describes your benefits as a Member of Health New England, Inc. ("HNE" or "the Plan"). It tells you what health care services and supplies HNE covers and how to get them. It is set up to help you find the information you need to know quickly and easily. The Table of Contents lists each section and where it is located. At the beginning of each section is a shaded box, containing a summary of the most important things to know about that section. We have provided the detail of each bulleted item in the text below the shaded box. Certain words in this Member Handbook that begin with a capital letter have a special meaning. These words are defined in Section 16 of this Member Handbook.

If you have any questions, please call us. For your convenience, HNE's telephone numbers appear at the bottom of each page, along with our web site. Our Member Services Representatives are available Monday through Friday, from 8:00 AM to 5:00 PM.

ABOUT HEALTH NEW ENGLAND (HNE)

Health New England is a Massachusetts licensed Health Maintenance Organization (HMO). An HMO is a health plan that requires you to get your care from specific doctors, hospitals, and other health care providers that contract with the Plan. We call these providers "In-Plan Providers."

HNE In-Plan Providers are independent contractors. HNE does not control the methods In-Plan Providers use to perform their work or to provide services. To find out what hospitals, doctors, and providers are in the HNE network, please refer to your "Plan Provider Directory," call HNE Member Services, or check the HNE web site. Printed Provider Directories are updated annually and from time to time throughout the year. Our web site is updated weekly. Please note that In-Plan Providers may have left or joined the Plan Provider network since the time of the last update. Because providers are free to join and leave our network at any time, HNE cannot guarantee the continued participation of any specific provider or group of providers listed in our Directory.

HNE's Service Area consists of the four counties of western Massachusetts (Hampden, Hampshire, Franklin, and Berkshire); part of Worcester County; as well as parts of Hartford, Litchfield, and Tolland Counties in northern Connecticut. With HNE, your monthly premium covers a large array of medical services, including preventive care when you are healthy, and care when you are injured or sick. When you receive care from In-Plan Providers, you will not have to submit claim forms or pay bills. However, you must pay a set dollar amount for certain services, such as doctors' visits, prescriptions, and emergency room visits. This set dollar amount is called a Copayment. Health care is covered only when Medically Necessary and appropriate. Your Primary Care Physician must provide or arrange your care, except when otherwise stated in this Member Handbook.

SECTION 2 – HOW TO OBTAIN BENEFITS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- You must choose a Primary Care Physician (PCP).
- If you need care, call your PCP.
- You do not need a referral for most specialty care from In-Plan Providers. This section describes exceptions.
- Always show your HNE ID Card when receiving services.
- In an Emergency, you may go straight to the emergency room (ER). If there is time, call your PCP first.
- If you do not follow the rules described in this Member Handbook, you may lose all or part of your coverage for that service or supply.

CHOOSING YOUR PRIMARY CARE PHYSICIAN (PCP)

Why must I choose a PCP?
Choosing a PCP is the first and most important decision you must make when you join HNE. Your PCP is the first person you should call when you need medical care. A PCP may be a doctor of internal medicine, family practice, general practice, or pediatrics. You may choose a different PCP for each member of your family. HNE's Provider Directory lists PCPs, their locations, and phone numbers. You can get a copy of our Provider Directory by calling HNE Member Services, or visit our web site.

If you choose a PCP that you have not seen before, we suggest you do the following:

- Call your PCP's office as soon as possible and tell the staff you are a new HNE Member.
- Make an appointment to see your new PCP so he or she can get to know you and begin taking care of any of your medical needs. You do not have to wait until you are sick to make this appointment. You should get to know your doctor as soon as possible.
- Ask your previous doctor(s) to send your medical records to your new PCP.

If you do not select a PCP when you enroll, we will automatically assign one to you. We will notify you in writing if your PCP stops being an In-Plan Provider. You will then need to select a new PCP. Please note that HNE will not cover services that you receive from an In-Plan PCP who is not listed by HNE as your PCP or your PCP's covering doctor.

What can I do if I am not happy with my PCP?
You can change your PCP by calling our Member Services Department. PCP changes will be effective on the next business day after your request. You may change to any PCP, unless the newly chosen doctor has notified HNE that he or she is no longer accepting new patients.

Can my PCP decide to transfer me to someone else?
Yes. Your PCP may request that you transfer to another In-Plan Doctor. HNE does not allow transfers based on the amount of medical services required by a Member or the physical condition of a Member. Your PCP must ask for HNE's approval before requesting a transfer to a new PCP. Your PCP must send you a letter requesting that you choose another PCP.

HOW TO OBTAIN MEDICAL CARE FROM AN IN-PLAN PROVIDER

How do I get medical care?
Call your PCP. It is your PCP's duty to provide or arrange most of your medical care. The services you receive must be Medically Necessary and either provided by or arranged through your PCP, except in an Emergency. Care by Out-of-Plan Providers must be approved, in advance, by HNE.

Do I need my Identification Card to receive care?
Yes. You must present your HNE ID Card to receive services. Your ID Card provides important information, such as: HNE's mailing address and telephone number; Subscriber name; Group number; benefit plan, including some Copayment amounts; identification number; as well as the name, Member number and PCP of each person covered. Having an ID Card does not guarantee you coverage for services. To have the right to receive Covered Services, you must be an HNE Member at the time you receive the service. If you permit others to use your ID Card to obtain services to which they are not entitled, your coverage may end. You should report the loss or theft of your ID Card to HNE as soon as possible. You may only use the most recent card provided to you by HNE.

What if I need Non-Emergency care after normal business hours?
At HNE, we know that medical problems may occur at any time — day or night. That is why we ask our PCPs to be on call 24 hours a day, seven days a week. You should talk to your PCP to find out about arrangements for care after normal business hours. At times, you may reach your PCP's answering service. You may also reach the doctor who is on call for your PCP. If you reach an answering service, here is what to do:

1. Say that you are an HNE Member.
2. Give your name and phone number.
3. Describe your symptoms.
4. Ask your doctor or the on-call doctor to call you back.

How do I get specialty care?
For most In-Plan specialty services, you don't need a referral. Just make your appointment, present your HNE ID card, and pay your usual Copayment. You need a referral for specialty care only when you need the following services:

- Dermatology.
- Allergy-related services from an allergist or otolaryngologist.
- Rehabilitative services of physical, occupational and speech therapy.
- Cardiac rehabilitation.
- Reproductive endocrinology.

In these instances, you must get a pink HNE In-Plan Specialty Referral Form from your PCP. You should know that your PCP might want to see you before giving you a referral. Your PCP will fill out the form and then ask you to make an appointment with an In-Plan Specialist.

If you need a referral:

1. You must bring the referral to the In-Plan Specialist at the time of your visit.
2. Your PCP's referral will be good for a limited time and number of visits. When either the time or the number of visits runs out, you must get a new one.
3. Your PCP may also authorize a standing referral to an In-Plan Specialist when he or she determines that it is appropriate and the In-Plan Specialist agrees to a treatment plan for you and provides your PCP with all the necessary clinical and administrative information regularly.

Note: This procedure does not apply to mental health or substance abuse services. To find out about obtaining mental health or substance abuse services, see "How to Get Mental Health or Substance Abuse Services" later in this section.

Whether or not you need a referral, it is your responsibility to make sure that the doctor your PCP refers you to is an HNE In-Plan Doctor. If you are not sure, check the Plan Provider Directory, visit the HNE web site, or call HNE.

Can I get podiatry services from a podiatrist?
HNE does not cover routine foot care, such as care of corns, calluses, and trimming of nails, unless you are a diabetic. However, other covered podiatry services, such as the treatment of podiatric diseases and conditions, are available from an In-Plan podiatrist. For additional information, see Section 4 – Exclusions and Limitations.

What do I do if I need to go into the hospital?
For non-Emergency care, talk to your PCP or treating In-Plan Provider. If you need to be admitted to a hospital, your PCP or treating In-Plan Provider will make the necessary hospital arrangements and supervise your care. Except in Emergencies, your treating In-Plan Provider must get HNE's Prior Approval before admitting you to a hospital.

How much do I pay for services?
Some HNE services are free of charge. For most services, however, you pay a set dollar amount. This is called a Copayment. Copayments are listed in Section 3 of this Member Handbook. Please remember that, in general, you must pay any Copayments at the time you receive services. **Other than Copayments, In-Plan Providers can not bill you for Covered Services. If you get a bill from an In-Plan Provider for a Covered Service that you received, please call HNE's Member Services Department.**

Do I have to submit claims?
The only time you may have to submit claims to HNE is if you receive Covered Services from an Out-of-Plan Provider as described in the sections below. If you receive services from an Out-of-Plan Provider, please be sure to show them your HNE ID Card. Most providers will bill HNE directly. If possible, ask the Out-of-Plan Provider to submit a standard medical claim form to HNE.

If the provider will not bill HNE directly, you must send us an itemized bill that includes the diagnosis and the date of treatment. For foreign medical bills and for some providers in the U.S., you may be required to pay the provider. If you pay the bill, send proof of your payment, along with a copy of the bill, to HNE. We will reimburse you for covered expenses, less any applicable Copayments.

You must have bills for Emergency care received in a foreign country translated into English. The bill must also convert charges to U.S. dollar values as of the date of service.

HOW TO OBTAIN MEDICAL CARE FROM AN OUT-OF-PLAN PROVIDER

What if I need to receive specialty care that is not available from an In-Plan Provider?
In order to receive specialty care from an Out-of-Plan Provider, you must first have the approval of HNE. In general, most health care services can be provided by HNE In-Plan Providers. Therefore, before HNE will consider a request for you to see an Out-of-Plan Provider, you must first have your PCP refer you to an In-Plan Specialist. If there is no In-Plan Specialist available to treat you, your PCP or treating In-Plan Provider will work with HNE to identify an appropriate Out-of-Plan Provider to treat you.

To initiate this process, your PCP or treating In-Plan Provider must submit a Prior Approval Request Form to HNE. **You cannot use a pink HNE In-Plan Specialty Referral Form to obtain services from an Out-of-Plan Provider.** HNE will notify you and your doctor in writing of its decision to approve or not approve the service. If you have not received a response from HNE, you should call HNE to determine whether HNE has approved your request. You should not make an appointment with the Out-of-Plan Provider before you receive HNE's response. **Please note:** HNE does not verify the credentials of Providers; only In-Plan Providers go through HNE's credentialing process.

What is an Emergency?
Massachusetts law defines an "Emergency" as follows:

> An emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Stated simply, an Emergency is a medical condition that you believe will place your life or health in serious danger if you do not receive immediate medical attention. In an Emergency, go to the nearest emergency facilities, call 911, or call your local emergency number. You are always covered for care in an Emergency. Your Primary Care Physician will arrange for any follow-up care you may need. Some problems are Emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Other problems are Emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisoning, inability to breathe, severe bleeding, loss of consciousness, and severe trauma. What all Emergencies have in common is a serious threat to health and the need for quick action.

Routine care, care that is not required immediately, or care of minor illnesses or injuries are not Emergencies. Examples of routine care or minor illnesses that are *not* Emergencies are: colds, minor sore throats, injuries of more than 24 hours' duration, or persistent or chronic illness treatable by your PCP.

All Members have the opportunity to obtain health care services for an Emergency Medical Condition. This includes the options of going to the nearest emergency facility, calling the local pre-hospital emergency medical service system, or dialing the emergency telephone access number (911), or its local equivalent, whenever you are confronted with an Emergency Medical Condition which, in the judgment of a prudent layperson, would require pre-hospital Emergency services.

No Member will be discouraged in any way from using emergency facilities, local pre-hospital emergency medical service systems, or the 911 telephone number, or the local equivalent.

No Member will be denied coverage for medical and transportation expenses incurred as a result of any Emergency Medical Condition which meets the above conditions.

What should I do in an Emergency?
You always have coverage for care in an Emergency. You do not need a referral from your PCP. However, in all cases, if your situation allows, call your PCP first. Say that you are an HNE Member and clearly state your symptoms. Your PCP may ask you to go to an emergency room or ask you to visit a doctor's office. Your PCP or a covering doctor is on call 24 hours a day, seven days a week.
If you do not have time to call your PCP, follow these rules:

When an Emergency Occurs:

- **Seek medical care at once. Go to the nearest emergency room (ER) or dial "911". (If two hospitals are equally close, use an In-Plan Hospital listed in the Plan Provider Directory.)**
- **Contact your PCP to notify him or her of your visit and to arrange for any follow-up care.**

If you are admitted to a hospital on an inpatient basis directly from the emergency room, you will not have to pay the emergency room Copayment. However, you will have to pay any applicable hospital admission Copayment.

What if I am out of the Service Area when an Emergency occurs?
If you are out of the HNE Service Area when an Emergency occurs, the guidelines listed above still apply. Call HNE Member Services to notify us of any Emergency services *not* received in a hospital emergency room (for example, at a walk-in clinic or physician's office). You should also be aware that HNE will not cover routine care, elective surgery, or care that you could have foreseen before leaving the HNE Service Area. In addition, your PCP must coordinate your follow-up care. HNE will not cover care (including follow-up care) you receive outside the Service Area once you are medically able to return to the Service Area.

What should I do if I am in an auto accident?
If you are in an auto accident, you should follow the rules in this Member Handbook, including the rules for obtaining care in an Emergency. Remember that all follow-up care must be coordinated by your PCP and be received from an In-Plan Provider. If you are not sure if the Provider that you are being referred to is an In-Plan Provider, please check your Provider Directory, visit our web site, or call our Member Services Department.

HOW TO GET MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES

How can I get mental health or substance abuse services?
To obtain treatment for mental health or substance abuse conditions, call HNE's Behavioral Health Triage Unit at 413-787-4000, ext. 5028 or 800-842-4464, ext. 5028. Your PCP or a family member may also call for you. A Behavioral Health Representative will help identify a provider for you based on your location and the nature of your concerns. The Behavioral Health Representative will refer you to an In-Plan Provider and give you a confirmation number to bring to your appointment.

SECTION 3 – COVERED BENEFITS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- To be covered, care must be Medically Necessary and appropriate; provided, referred, or arranged by your PCP; and, unless approved in advance by your PCP and HNE, provided by an In-Plan Provider.
- Some services are *not* covered.
- Many services require you to pay a Copayment at the time of service.

HNE will cover the services and supplies described in this section only if they are Medically Necessary and appropriate. Your PCP must provide or arrange most of your health care following HNE policies and rules. Treatment by an Out-of-Plan Provider requires the advance written approval of both your PCP (or treating In-Plan Provider) *and* HNE. The only exceptions are the Emergency situations described in this Member Handbook.

All covered care is subject to the conditions in this Member Handbook. You should read Section 4 to learn more about care that is limited or excluded. HNE does not pay for medical care unless it is a Covered Benefit as described in this Member Handbook. HNE also does not cover medical care that is not provided and obtained as required by this Member Handbook.

CHART OF BENEFITS

The chart on the following pages is only a summary guide that we have included to assist you in locating certain benefits. The detail for each of these benefits, including any limitations or exclusions associated with the benefit, can be found on the pages referenced. You are responsible for the Copayments listed on the Chart of Benefits.

ANNUAL COPAYMENT MAXIMUM FOR MEDICAL OFFICE VISITS

This plan has a Copayment maximum of $225 per individual and $375 per family per Calendar Year for medical office visits. If you reach this Copayment maximum, HNE will reimburse you (or your family) for any other medical office visit Copayments you make in excess of the Copayment Maximum. You may submit your receipts for the medical office visit Copayments only at the end of the Calendar Year. You must keep receipts of the Copayments you make as proof that you have reached the Copayment Maximum. Each receipt must indicate the date of service and clearly state that the receipt is from a medical office. You will have to continue to pay a Copayment for all other services as indicated on the following chart. **Please note: It is your responsibility to notify HNE once you, one of your Dependents, or your family reaches the Copayment maximum at the end of a Calendar Year.** To obtain reimbursement, send a request in writing to HNE's Member Services Department. Be sure to include your name, address, Member ID number and proof of payment (e.g., provider invoice or receipt only). **Requests for reimbursement must be received by HNE within 90 days of the end of the Calendar Year for which you are seeking reimbursement. For example, a reimbursement request for Copayments that you pay in excess of the Copayment Maximum from January 1st through December 31st of 2004, must be received by HNE no later than March 31, 2005.**

Do all services which include a Copayment count towards the Annual Copayment Maximum?
No. Only Copayments of $15 which you pay for medical office visits count towards the annual medical office visit Copayment maximum. There is a separate Annual Copayment Maximum for outpatient mental health and substance abuse service visits. *(See page 22 for a description of this).* You will have to continue to pay a Copayment for all other services as indicated on the following chart.

Benefit	*Copayment*	*Page*
PRESCRIPTION DRUGS (certain drugs require HNE's Prior Approval)		**11**
At an In-Plan Pharmacy (up to a 30-day supply):		11
Generic drugs	$10	
Formulary brand name drugs	$20	
Non-Formulary brand name drugs	$40	
Through Mail Order (up to a 90-day supply of maintenance medication):		11
Generic drugs	$20	
Formulary drugs	$40	
Non-Formulary drugs	$120	
INPATIENT CARE (Elective admissions require Prior Approval)		**15**
Acute Hospital Care	$200/admission*	15
Skilled Care Facility	$0	15
Rehabilitation Care Facility	$200/admission*	15
OUTPATIENT CARE		**16**
Preventive Care:		16
Routine Physical Examinations and Immunizations	$15/visit	16
Well Child Care	$15/visit	16
Eye Examinations	$15/visit	17
Hearing Tests	$15/visit	17
Annual Gynecological Exam	$15/visit	17
Mammographic Exam	$0	17
Specialist Office Visits	$15/visit	17
Diabetic-Related Items:		17
Outpatient Services (some services require HNE's Prior Approval)	$15/visit	
Laboratory/Radiological Services	$0	
Durable Medical Equipment (some DME requires HNE's Prior Approval)	$0	
Emergency Room Care	$50/visit	18
Diagnostic Testing (some services are subject to the Outpatient Surgical Services Copayment, see benefit description):		18
In a Doctor's Office	$15	
In Other Surgical Settings	$75**	
Laboratory/Radiological Services (some services require HNE's Prior Approval)	$0	18
Outpatient Short-term Rehabilitation Services	$15/visit/treatment type	18
Early Intervention Services	$15/visit	19

* Maximum of four inpatient admission Copayments per Calendar Year.
** Maximum of four outpatient Surgical Services Copayments per Calendar Year.

Benefit	*Copayment*	*Page*
OUTPATIENT CARE (continued)		
Outpatient Surgical Services (some services require HNE's Prior Approval):		19
In a Doctor's Office	$15/visit	
In a Hospital	$75**	
Second Opinions	$15/visit	**19**
Allergy Testing and Treatment	$15/visit	**19**
Allergy Injection Only	$0	**19**
Speech, Hearing and Language Disorders	$15/visit	**19**
FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT (some Infertility treatments require HNE's Prior Approval)		**20**
Family Planning Information, Counseling and Treatment	$15/visit	
Infertility Counseling and Treatment	$15/visit	
Laboratory Tests	$0	
Inpatient Care	$200/admission*	
Outpatient Surgery	$75**	
MATERNITY CARE		**21**
Prenatal and Postpartum Care	$0	
Delivery/ Hospital Care for Mother and Child	$200/admission*	
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (requires HNE's Prior Approval)		**22**
Mental Health Services:		22
Inpatient services	$0	
Intermediate services (such as Partial Hospitalization)	$0	
Outpatient services	$15/visit	
Substance Abuse Services:		23
Inpatient Services	$0	
Intermediate services (such as Partial Hospitalization)	$0	
Outpatient Services	$15/visit	
DENTAL SERVICES		**23**
Inpatient Surgical Treatment of Non-Dental Conditions (requires HNE's Prior Approval)	$200/admission*	23
Emergency Dental Care:		23
In a Doctor's Office	$15/visit	
At an Emergency Room	$50/visit	
Other Covered Dental Procedures (in an outpatient surgical setting)	$75**	23

* Maximum of four inpatient admission Copayments per Calendar Year.
** Maximum of four outpatient surgery Copayments per Calendar Year.

Benefit	*Copayment*	*Page*
OTHER SERVICES		**24**
Home Health Care (requires HNE's Prior Approval)	$0	24
Hospice Services (requires HNE's Prior Approval)	$0	25
Durable Medical and Prosthetic Equipment (some items require HNE's Prior Approval)	20% Copayment	25
Ambulance and Chair Van Services	$25 per day per Member	25
Reconstructive or Restorative Surgery:		26
Inpatient Services	$200/admission*	
Outpatient Surgical Setting	$75**	
Kidney Dialysis	$0	26
Human Organ Transplants (requires HNE's Prior Approval)	$200/admission*	26
Nutritional Support (requires HNE's Prior Approval)	$0	27
Cardiac Rehabilitation	$15/visit	28
Nurse Anesthetists and Nurse Practitioners	$15/visit	28
Scalp Hair Prostheses (Wigs)	All costs over $350	28
Coronary Artery Disease/Change of Heart Program	10% Copayment	28
Hearing Aids	See benefit description	28
Nutritional Counseling (maximum of two visits per Calendar Year)	$15/visit	28

* Maximum of four inpatient admission Copayments per Calendar Year.
** Maximum of four outpatient surgery Copayments per Calendar Year.

PRESCRIPTION DRUGS

Prescription drugs are substances that you can obtain only with the prescription of an HNE In-Plan Doctor. There are a few prescription drugs that HNE does not cover. There are also some drugs for which HNE provides limited, rather than full, coverage.

Copayments

There are three levels (or tiers) of Copayments for prescription drugs, depending on whether the drug is classified as a Generic, Formulary, or Non-Formulary drug. (These terms are defined below.) In addition, there are two ways to purchase prescribed drugs – either at an In-Plan pharmacy or through mail order. How you buy your prescribed drugs also affects how much you pay. Copayments must be paid to the pharmacy at the time of purchase.

At an In-Plan Pharmacy You Pay for up to a 30-day supply:

- **$10 per prescription or refill for Generic drugs**
- **$20 per prescription or refill for brand name Formulary drugs**
- **$40 per prescription or refill for brand name Non-Formulary drugs**

Prescription drugs filled at an In-Plan Pharmacy are limited to one 30-day supply per prescription. If the applicable Copayment is more than the retail price of a drug, the Member pays the retail price. Each Copayment covers up to a 30-day supply of a prescription or refill. If the prescription is for less than a 30-day supply of a medication, a full Copayment applies. Each of the Copayments listed above applies to a 30-day supply or less. The quantity of drugs in a 30-day supply is based on normal dosages. See the "Prescription Drug Limitations" later in this section of the Member Handbook for further information.

Through HNE's national network, you may obtain prescriptions at participating pharmacies wherever they're located, or at certain other pharmacies that do not have locations in Western Massachusetts. To find a nearby participating pharmacy, refer to your Plan Provider Directory or call HNE Member Services at 800-310-2835 or 413-787-4004, Monday-Friday, 8 a.m.-5 p.m.

Through Mail Order you pay for up to a 90-day supply of maintenance medication:

- **$20 per prescription or refill for Generic drugs**
- **$40 per prescription or refill for brand name Formulary drugs**
- **$120 per prescription or refill for brand name Non-Formulary drugs (note that there is no cost advantage to obtaining a brand name Non-Formulary drug through mail order)**

You may obtain a 90-day supply of maintenance drugs through an HNE participating mail order supplier. Maintenance drugs include medications taken for a chronic illness. In general, a medication is classified as "maintenance" if it: (1) is used for chronic illnesses such as asthma, allergies, high blood pressure, etc.; and (2) has been obtained by prescription at least twice at a participating pharmacy. Each of the Copayments listed above applies to a 90-day supply or less. The quantity of drugs in a 90-day supply is based on normal dosages. See "Prescription Drug Limitations" later in this section of the Member Handbook for further information. Please call HNE Member Services for information about how to obtain prescriptions through mail order. The following items may not be purchased through the mail service:

- Compounded medications requiring the mixing of drugs by a pharmacist.
- Any drugs for which mail service is prohibited by law.
- Prescriptions for which a 90-day supply may not be appropriate as determined by HNE.
- Narcotics.
- Injectables.
- Medications that require Prior Approval (see below for list).
- Medications with quantity limits.

Drug Classifications
HNE covers most prescription drugs and a small number of non-prescription drugs and medical supplies that are ***Medically Necessary*** for preventive care or treating illness, injury or pregnancy.

Generic and Brand/Formulary drugs comprise the HNE Formulary. If a medication is not in the HNE Formulary, it is considered Brand/Non-Formulary. Members still have access to these medications, but at higher Copayments. HNE does not waive or reduce Copayments for any prescription drugs.

Typically HNE does not add brand name medications to its list of covered drugs for at least six months after FDA approval. Once the FDA approves a drug, HNE's committee of physicians and pharmacists reviews the drug's safety, effectiveness and value. During this clinical review period, HNE does not cover the drug.

HNE also establishes exclusions and limitations on drug coverage. We rely on input from a team of doctors and pharmacists who are advised by physician consultants from numerous medical specialties.

Generic: A Generic drug is a drug that is not protected by a trademark. Generic drugs contain the same active ingredients as brand name drugs and deliver the same amount of medication to the body in the same amount of time. The Food and Drug Administration (FDA) reviews Generic drugs to assure that they are safe and effective. Generic drugs are generally a much better value than brand name drugs, so a lower Copayment applies. **Note: Unless your doctor has written "no substitution" on your prescription, a Massachusetts pharmacy is required by state law to give you a Generic drug if one is available.**

Formulary: The Formulary is a list of HNE-approved ***brand name*** drugs. A committee of physicians and pharmacists considers a drug's quality, cost, safety, and performance and places drugs on the Formulary. HNE revises the Formulary from time to time. You will pay a lower Copayment for brand name drugs if they are listed in the Formulary. The Formulary is reprinted and distributed, by mail, to all HNE clinicians each January and includes all changes made during the previous year. The Formulary is made available to all participating pharmacies. Drugs added or deleted from the Formulary during the year are communicated through HNE's Member and provider newsletters. To find out if the drug you use is in the Formulary, or to request a copy of the Formulary, call HNE Member Services or visit our web site.

Non-Formulary: Non-Formulary drugs are also brand name drugs. However, we have found that these drugs have no special advantage over Formulary drugs that are used to treat the same condition. Non-Formulary drugs are generally more expensive than Formulary drugs. Therefore, when your doctor prescribes a Non-Formulary drug, you will pay a higher Copayment.

Self-Administered Injectable Medications
Some injectable medications may be injected by properly trained medical staff only. These medications are covered in full when provided during a Covered Service. Other injectable medications are available at retail pharmacies, and may be self administered, that is, injected by the patient him- or herself. These medications are covered under HNE's pharmacy benefit even if injected by an In-Plan Provider. For a list of self-administered injectable medications, please contact HNE Member Services.

WHAT IS COVERED:
HNE covers the following items under the prescription drug benefit:

- Compounded medications.
- Drugs that require a prescription.
- All birth control drugs and devices that have been approved by the FDA.
- The following non-prescription drugs: insulin, niacin, and Gyne-Lotrimin.
- Off-label uses of drugs for the treatment of cancer and HIV/AIDS.
- The following medical supplies: needles and syringes for use with covered drugs and insulin; blood glucose monitoring strips and lancets for diabetics.

WHAT IS NOT COVERED:
Items that are not covered under the prescription drug benefit include, but are not limited to, the following:

- Vitamins (except prescription prenatal vitamins and prescription neonatal vitamins with fluoride for infants up to one year of age).
- Experimental drugs.
- Drugs for cosmetic purposes, including, but not limited to:
  - Avage®.
  - Eldopaque Forte®.
  - Glyquin XM®.
  - Hydroquinone products.
  - Lustra®.
  - Melenex®.
  - Penlac®.
  - Propecia®.
  - Renova®.
  - Rogaine®.
  - Solage®.
  - Solaquin Forte®.
  - Tri-Luma®.
  - Vaniqa®.
- Infertility medications for donors.
- Medications for Assisted Reproductive Technology (ART) cycles/attempts without Prior Approval.
- Non-prescription drugs or medicines.
- Drugs that are not Medically Necessary and appropriate.
- Gonal-F® multidose kit.
- Singulair® will not be covered when prescribed to treat allergies. It will be covered when prescribed to treat asthma.
- Xyrem®**,** a prescription drug.

DRUGS THAT REQUIRE HNE'S PRIOR APPROVAL:

In order for you to obtain certain drugs, your prescribing In-Plan Doctor must obtain HNE's Prior Approval. HNE's pharmacy benefit manager, Express Scripts®, performs prior review using HNE-approved criteria. If the request meets guidelines, it is approved by an Express Scripts® Prior Authorization Coordinator. If a request does not meet Prior Approval criteria, the Prior Authorization Coordinator will discuss the request with an Express Scripts® Clinical Pharmacist to resolve any questions related to Medical Necessity. The following list includes the drugs requiring Prior Approval as of the date this Explanation of Coverage was printed (F = Formulary and NF = Non-Formulary):

- Actiq® (NF) – for cancer pain.
- Antagon® (F) – for Infertility.
- Arava® (F) – for rheumatoid arthritis (Prior Approval not required when prescribed by a rheumatologist).
- Bextra® (NF) – for arthritis.
- Bravelle® (F) – for Infertility.
- Celebrex® (F) – for arthritis.
- Cetrotide® (F) – for Infertility.
- Emend® (NF) – for chemotherapy (Prior Approval not required when prescribed by a hematologist or oncologist).

- Enbrel® (F) – for rheumatoid arthritis and psoriasis (Prior Approval not required when prescribed by a rheumatologist).
- Fertinex® (F) – for Infertility.
- Follistim® (F) – for Infertility
- Follistim (Antagon kit) (F) – for Infertility.
- Gonal-F® (F) – for Infertility.
- Humira® (F) – for rheumatoid arthritis (Prior Approval not required when prescribed by a rheumatologist).
- Kineret®(NF) – for rheumatoid arthritis (Prior Approval not required when prescribed by a rheumatologist).
- Meridia® (NF) – for weight loss.
- Metrodin® (F) – for Infertility.
- Mobic® (NF) – for arthritis.
- Pergonal® (F) – for Infertility.
- Provigil® (NF) – for narcolepsy and fatigue from multiple sclerosis.
- Raptiva® (NF) – for psoriasis.
- Repronex® (F) – for Infertility.
- Singulair® (F) – for asthma. Singulair will be covered only when prescribed to treat asthma. It will not be covered when prescribed to treat allergies.
- Tracleer® (NF) – for primary pulmonary hypertension.
- Vfend® (NF) – antifungal (Prior Approval not required when prescribed by a hematologist, oncologist or infectious disease specialist).
- Vioxx® (F) – for arthritis.
- Xenical® (NF) – for weight loss.
- Zyvox® (NF) – for infection.

The below injectable drugs also require Prior Approval. They are part of your medical benefit and not part of your prescription drug benefit. Prior Approval for these drugs is done by HNE's Health Services Department:

- Remicade®.
- Human growth hormones.
- Xolair®
- Amevive®

PRESCRIPTION DRUG LIMITATIONS:
HNE limits the coverage of certain drugs for reasons of cost and to assure their safe and effective use. HNE may place limits on the quantity of a drug covered, the amount that can be obtained for each Copayment, or the medical conditions for which a covered drug may be prescribed. The following list includes the drugs that are covered only for a limited quantity, or which limit the quantity that can be obtained, for each Copayment (F = Formulary and NF = Non-Formulary):

- Actiq: 120 swabs per 30-day period (NF).
- Ambien®: 14 tablets per 30-day period (NF).
- Amerge®: 18 tablets per 30-day period (NF).
- Axert®: 18 tablets per 30-day period (NF).
- Caverject®: 4 doses per Copayment, 1 fill per 30-day period (F).
- Cialis®: 4 tablets per 30-day period (NF).
- Clozaril®: 14-day supply per prescription (NF) **NOTE: ½ Copayment per fill.**
- Edex®: 4 doses per Copayment, 1 fill per 30-day period (F).
- Frova®: 18 tablets per 30-day period (NF).
- Humira®: 2 injections per 30-day period (F).
- Imitrex® injection: 2 boxes (4 injections) per 30-day period (F).
- Imitrex nasal spray: 6 units per 30-day period (F).

- Imitrex tablets: 18 tablets per 30-day period (F).
- Lamisil®: 1 90-day supply per Member per Calendar Year (NF).
- Levitra®: 4 tablets per 30-day period (NF).
- Maxalt®/Maxalt MLT tablets: 18 tablets per 30-day period (NF).
- MUSE®: 4 doses per Copayment, 1 fill per 30-day period (F).
- Nicotine Patches: 30 patches per prescription, 90-day supply per Calendar Year (F).
- Nicotrol® inhaler: 168 units per prescription, 90-day supply per Calendar Year (NF).
- Nicotrol® nasal spray: 4 units per prescription, 90-day supply per Calendar Year (NF).
- Ortho Evra®: 3 patches per 30-day period (NF).
- OxyContin®: 4 tablets per day or up to 120 tablets per 30-day period. No limitation if prescribed by a hematologist or oncologist (F).
- Regranex®: 1 tube per 30 days, 90-day supply per year (NF).
- Relenza®: 1 kit per prescription (NF).
- Relpax®: 18 tablets per 30-day period. (NF).
- Sonata®: 14 capsules per 30-day period (NF).
- Sporonox®: 1 90-day supply per Member per Calendar Year. (NF).
- Toradol®: 20 tablets (5-day supply) per prescription (NF).
- Transderm Scop®: 1 box (4 patches) per Copayment (F).
- Viagra®: 4 doses per Copayment, 1 fill per 30-day period (F).
- Zomig®/Zomig ZMT® tablets: 18 tablets per 30-day period (F).
- Zomig® Spray: 6 units per 30-day period (F).
- Zyban®: 60 tablets per prescription, 90-day supply per Calendar Year (NF).

HNE will notify you of any changes to the list of drugs that are excluded or limited through our Member newsletter or through a direct mailing. For an updated listing, call HNE Member Services or visit our web site.

INPATIENT CARE

In order to receive elective inpatient hospital care, a Member must get HNE's Prior Approval. Your PCP or treating In-Plan Provider will make the arrangements for your care. He or she will coordinate any diagnostic or pre-admission work-ups. There are a maximum of four inpatient admission Copayments per Calendar Year. There are a maximum of four outpatient surgery Copayments per Calendar Year.

A. Acute Hospital Care (Elective admissions Require HNE's Prior Approval): **You Pay… $200**

HNE covers acute hospital care to the extent Medically Necessary. There is no limit per Calendar Year on the number of days covered.

B. Skilled Care Facility (Requires HNE's Prior Approval): **You Pay… $0**

HNE covers non-Custodial Care in a facility licensed to provide skilled nursing care on an inpatient basis. (For a definition of Custodial Care, see Section 16 – Definitions.) HNE will cover up to a combined maximum of 100 days per Calendar Year for care you receive in either a skilled care facility or a rehabilitation care facility. Services will only be covered when you need daily skilled care that must be provided in an inpatient setting. All skilled care is subject to HNE's Prior Approval and ongoing medical review for medical necessity.

C. Rehabilitation Care Facility (Requires HNE's Prior Approval): **You Pay… $200**

HNE covers non-Custodial Care in a facility, or part of one, licensed to provide rehabilitative care on an inpatient basis. HNE will cover up to a combined maximum of 100 days per Calendar Year for care you receive in either a skilled care facility or a rehabilitation care facility. Services will only be covered when you need daily rehabilitative services that must be provided in an inpatient setting. All inpatient rehabilitation is subject to HNE's Prior Approval.

WHAT IS COVERED:
Admission into any inpatient facility includes, but is not limited to, the following services:

- Semi-private room and board.
- Private room (when Medically Necessary and ordered by a doctor).
- Physician and surgeon services.
- General nursing services.
- Laboratory and pathology services.
- Intensive care.
- Coronary care.
- Dialysis services.
- Short-term rehabilitation services.

WHAT IS NOT COVERED:
Items or services that are not covered under the inpatient care benefit include, but are not limited to, the following:

- Personal or comfort items, including telephone and television charges, during hospitalization or as an outpatient
- Rest or Custodial Care or long-term care
- Blood or blood products, including the cost of donating and storing blood for use during surgery or other medical procedure
- Charges after the date on which your membership ends
- Unskilled nursing home care
- Any additional charges incurred for a patient who remains in the hospital for his/her convenience beyond the discharge hour

OUTPATIENT CARE

HNE covers outpatient care that you receive from your PCP at a doctor's office or in a hospital. HNE also covers care that you receive upon referral from your PCP to an HNE In-Plan Provider. The only times your PCP does not need to provide or arrange your care is in an Emergency or for specialty services that do not require a referral.

A. Preventive Care:
HNE covers preventive care according to your individual medical needs. Your PCP generally provides these services.

1. Routine Physical Examinations and Immunizations **You Pay… $15 per visit**
HNE covers preventive periodic health exams and immunizations for adults and children over age 6. The frequency of covered preventive exams depends on the age and health status of the Member.

2. Well Child Care **You Pay… $15 per visit**
HNE covers well child care for children from birth until age 6. HNE will cover physical examination, history, measurements, sensory screening, and developmental screening and assessment at the following intervals: six times during the child's first year after birth; three times during the next year; and then, annually until age 6.

HNE covers hereditary and metabolic screening at birth; appropriate immunizations; tuberculin tests; hematocrit, hemoglobin, or other appropriate blood tests; and urinalysis as recommended by the In-Plan Doctor. HNE covers lead screening in accordance with Massachusetts law. HNE also covers necessary care and treatment of medically diagnosed congenital birth defects and birth abnormalities or premature birth.

3. Eye Examinations **You Pay… $15 per visit**

HNE covers one routine eye examination each Calendar Year. You may schedule your exam by calling an In-Plan optometrist or ophthalmologist. *As with most other specialty services, no referral is required.*

4. Hearing Tests **You Pay… $15 per visit**

HNE will cover hearing tests when Medically Necessary.

5. Annual Gynecological Exam **You Pay… $15 per visit**

HNE covers one routine gynecological exam per Calendar Year. Coverage includes a Pap smear (cytological screening) and pelvic exam. In addition, HNE covers any subsequent obstetric or GYN services determined by that provider to be Medically Necessary because of such exam. You may schedule your exam by calling an In-Plan OB/GYN. *You do not need a referral.*

6. Mammographic Exams **You Pay… $0**

HNE covers mammographic exams as follows:

- One baseline mammogram for women who are between the ages of 35 and 40.
- On an annual basis for women forty years of age and older.
- Otherwise, when Medically Necessary and appropriate.

WHAT IS NOT COVERED:

Services that are not covered under the outpatient care benefit include, but are not limited to, the following:

- Services that a third party or court order requires. For example, employment, school, sports, pre-marital, and summer camp examinations are not covered.
- Services associated with hiring requirements.

B. Specialist Office Visits: **You Pay… $15 per visit**

You must get a pink HNE In-Plan Specialty Referral from your PCP for the following services:

- Dermatology.
- Allergy-related services from an allergist or otolaryngologist.
- Rehabilitative services of physical, occupational and speech therapy.
- Cardiac rehabilitation.
- Reproductive endocrinology.

See "How do I get specialty care?" in Section 2.

Obstetric/Gynecology services – All female Members may receive the services listed below from an obstetrician, gynecologist, certified nurse midwife, or family practitioner without a referral:

- Annual preventive GYN health exams, including any subsequent obstetric or GYN services determined by that provider to be Medically Necessary because of such exam.
- Maternity care.
- Medically Necessary evaluations and health care services for GYN conditions.

You may schedule these visits yourself. Normal Copayment rules apply to these visits. (See also Preventive Care, Maternity Care)

C. Diabetic-Related Items:

HNE will cover the following items and services when they are prescribed by an In-Plan Provider and are Medically Necessary for the diagnosis or treatment of insulin-dependent, insulin-using, gestational, and non-insulin-dependent diabetes:

1. Outpatient services **You pay… $15 per visit**

HNE covers outpatient diabetes self-management training and education, including medical nutrition therapy and nutritional counseling. All of these services except nutritional counseling require HNE's Prior Approval.

2. Laboratory/radiological services **You pay… $0**

HNE covers laboratory tests including glycosylated hemoglobin, HbAlc tests, urinary protein/microalbumin, and lipid profiles.

3. Durable medical equipment (DME) **You pay…$0**

HNE covers the following durable medical equipment for diabetics:

- Blood glucose monitors.
- Voice synthesizers for blood glucose monitors for use by the legally blind.
- Visual magnifying aids for use by the legally blind.
- Insulin pumps and insulin pump supplies (*requires HNE's Prior Approval*).
- Therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease. The need for therapeutic shoes and shoe inserts must be certified by the treating doctor and prescribed by an In-Plan podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist, or pedorthist (*requires HNE's Prior Approval*).

4. Prescription drugs **You pay… applicable prescription drug Copayment**

HNE covers the following items under the prescription drug benefit. See the prescription drug benefit for information about Copayment amounts.

- Blood glucose monitoring strips, urine glucose strips, and ketone strips
- Lancets
- Insulin, insulin pens, and insulin syringes
- Prescribed oral diabetes medications that influence blood sugar levels

D. Emergency Room Care: **You Pay… $50 per visit (waived if admitted directly from ER)**

See Section 2 for information about how to obtain care in an Emergency. If you need follow-up care after you are treated in an emergency room, you must call your PCP. He or she will provide or arrange for the care you need.

WHAT IS NOT COVERED:

Services that are not covered under the emergency room care benefit include, but are not limited to, the following:

- Follow-up care, unless provided or arranged by your PCP.
- Non-Emergency care provided in an emergency room.
- Care that you could have foreseen before leaving the HNE Service Area.
- Care from an Out-of-Plan Provider once you are medically able to return to the Service Area.

E. Diagnostic Testing: **You Pay… $15 in a doctor's office**
$75 in other surgical settings

HNE covers outpatient diagnostic testing to diagnose illness, injury, or pregnancy. ***Note: Some services, including, but not limited to, sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies are covered under the outpatient surgical services benefit.***

F. Laboratory and Radiological Services (some services require HNE's Prior Approval) **You Pay… $0**

HNE covers laboratory testing and radiological services when performed in a doctor's office or other lab facility. These services include, but are not limited to: x-rays, ultrasound, mammography, and diagnostic imaging. In order to be covered, the following diagnostic imaging procedures require Prior Approval: Computerized Tomography (CT) scans; Positron Emission Tomography (PET) scans; Magnetic Resonance Imaging (MRI); and Magnetic Resonance Angiograms (MRA).

G. Outpatient Short-term Rehabilitation Services: **You Pay… $15 per visit per treatment type**

Short-term rehabilitation services include physical, occupational, and respiratory therapy. HNE only covers short-term therapy for rehabilitation. This benefit is limited to 90 days per acute episode, per Calendar Year for physical, occupational and respiratory therapy; there is no limit for speech therapy. *(See page 19 for a description of speech therapy coverage.)* The benefit is unlimited when provided as part of a home health care plan. There must be

objective, measurable improvements in your medical or clinical condition during the course of the therapy for coverage to continue.

HNE does not cover rehabilitative treatment for non-acute chronic conditions. Chronic conditions are those that exist for an extended time or continue past the expected recovery time for acute or short-term conditions. For example, HNE defines chronic pain as pain continuing more than three months after the injury or illness causing the original pain. HNE will cover treatment for acute episodes of an illness related to your chronic condition.

HNE does not cover maintenance treatment. Maintenance treatment is designed to retain health or bodily function, to continue your current state or condition, or to monitor your current state or condition. HNE only covers therapy that will lead to significant measurable improvement in your condition and not just temporary improvement or relief of symptoms.

WHAT IS NOT COVERED:
Services that are not covered under the outpatient short-term rehabilitation benefit include, but are not limited to, the following:

- Massage therapy, including myotherapy.

H. Early Intervention Services: **You Pay… $15 per visit**

Covered Services consist of Medically Necessary early intervention services delivered by certified early intervention specialists who are working in early intervention programs certified by the Department of Public Health. Coverage is provided for Members from birth until age 3. Benefits are limited to $3,200 per child per Calendar Year, with a lifetime maximum of $9,600 per child.

I. Outpatient Surgical Services: **You Pay… $15 in a doctor's office**
$75 in a hospital

HNE covers outpatient or ambulatory surgery, including related services. In addition, HNE covers certain procedures, such as sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies under the outpatient surgical services benefit. *Certain outpatient surgical services require Prior Approval by HNE.* Examples include, but are not limited to, the following: laser-assisted uvulopalatoplasty or uvulopalatopharyngoplasty (corrective surgery of the palate, uvula, or related structures); oral surgery for treatment of non-dental conditions; reduction mammoplasty; and rhinoplasty. HNE will only approve these services if they are Medically Necessary Covered Services and meet HNE's clinical review criteria.

J. Second Opinions: **You Pay… $15 per visit**

HNE covers second opinions from an In-Plan Provider.

K. Allergy Testing and Treatment: **You Pay… $15 per visit**

HNE covers testing, antigens, and allergy treatments. **$0 Copayment for allergy injection only**

L. Speech, Hearing and Language Disorders: **You Pay… $15 per visit**

This plan covers Medically Necessary diagnosis and treatment of speech, hearing and language disorders. HNE will not cover these services when available in a school-based setting.

You Pay…

- **$15 per visit for outpatient care, except as otherwise listed.**
- **$0 for laboratory tests.**
- **$200 for inpatient care.**
- **$75 for outpatient surgery.**

A. Family Planning Services

HNE covers family planning services when provided by your PCP or an In-Plan OB/GYN Provider. This includes pregnancy testing and genetic counseling. *Services obtained from an In-Plan OB/GYN Provider do not require a referral.*

WHAT IS COVERED:

HNE covers the following services under the family planning benefit:

- Counseling and diagnostic services for genetic problems and birth defects.
- Family planning information and consultation.
- Pregnancy testing.
- Sterilizations.
- Voluntary termination of pregnancy.
- Outpatient contraceptive services, including consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the Food and Drug Administration.
- Birth control drugs, devices, implants and injections that have been approved by the FDA.

WHAT IS NOT COVERED:

- Reversal of voluntary sterilization.

B. Infertility Treatment (Requires HNE's Prior Approval):

Your PCP must refer you for Infertility treatment. *For Assisted Reproductive Technologies, your PCP or treating In-Plan Provider must obtain HNE's approval for the services to be covered.* HNE will cover these services in accordance with the terms of HNE's Infertility Protocol. Benefit limits and exclusions are also listed in the Protocol. You may call HNE Member Services for a copy of the Protocol.

WHAT IS COVERED:

HNE covers the following Infertility services:

- Consultation and evaluation.
- Laboratory tests.
- Artificial insemination.
- Intrauterine insemination (IUI).
- Assisted Reproductive Technologies, including, but not limited to:
  - in-vitro fertilization and embryo placement (IVF-EP).
  - gamete intrafallopian transfer (GIFT).
  - zygote intrafallopian transfer (ZIFT).
  - intra-cytoplasmic sperm injection (ICSI) for the treatment of male factor Infertility.

  (All requests for Assisted Reproductive Technologies must be submitted to HNE for Prior Approval.)
- Sperm, egg and/or inseminated egg procurement, processing, and banking when associated with an approved active cycle, to the extent such costs are not covered by the donor's insurer.

WHAT IS NOT COVERED:

Services that are not covered under the Infertility benefit include, but are not limited to, the following:

- Any Infertility services, including consultations, testing and procedures, if either the Member or their spouse has previously undergone a voluntary sterilization or its reversal.
- Infertility treatment for Members who are not medically infertile.
- Any costs associated with any form of surrogacy, including gestational carriers.
- Non-mandated Infertility treatments.
- Cryopreservation of eggs.
- Procedures associated with gender selection, convenience, or genetic engineering.
- Early diagnosis of genetic or chromosomal abnormalities.
- Donation or sale of gametes or embryos.
- Clinical or laboratory research.
- Any fees to a donor or program for donation of sperm/egg(s).
- Infertility medications for donors.
- Medications for ART cycles/attempts without Prior Approval.
- Assisted hatching.

MATERNITY CARE

YOU PAY… $200 PER ADMISSION

You do not need a referral for prenatal care. However, you do need to get this care from an In-Plan OB/GYN Provider. An In-Plan OB/GYN Provider must make all arrangements for inpatient care.

Important Notice of Rights

Massachusetts law (M.G.L. c.111, *§* 51) gives you the right to stay in the hospital with your baby for at least 48 hours after giving birth (or 96 hours after birth if you have a cesarean section). If this time period ends between 8:00 PM and 8:00 AM, you have the right to stay in the hospital until after 8:00 AM, unless you want to leave earlier. If you would like to go home from the hospital early (before 48 hours after giving birth or 96 hours after a cesarean section), you may do so. If you choose to leave early, HNE will cover one home visit to check you and your new baby. This home visit must occur within 48 hours after you go home.

If you have any questions about your rights under this law, talk to your doctor or nurse, or call the Department of Public Health at 617-624-6095.

If you feel your rights have been denied under this law, you may file an appeal with the Department of Public Health at 800-436-7757. TDD/TTY 800-439-2370. Filing an appeal will prevent you from being discharged while the appeal is being considered.

WHAT IS COVERED:
HNE covers the following services under the maternity care benefit:
- Prenatal and postpartum care, including outpatient lactation consultation.
- Diagnostic tests.
- Delivery.
- Routine nursery charges (This includes common services given to a healthy newborn. For continued coverage of your child, you must enroll your child as a Member within 31 days of the date of birth.)
- Newborn hearing screening.
- One home visit if you choose to leave the hospital early.

WHAT IS NOT COVERED:
Services that are not covered under the maternity benefit include, but are not limited to, the following:
- Routine maternity (prenatal and postpartum) care when you are traveling outside the HNE Service Area.
- Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery.
- Home deliveries.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

All mental health and substance abuse services must be approved in advance by Health New England. To obtain treatment for mental health or substance abuse, call HNE's Behavioral Health Triage Unit at 413-787-4000, ext. 5028 or 800-842-4464, ext. 5028. Your PCP or a family member may also call for you. A Behavioral Health Representative will help identify a provider for you based on location and the nature of your concerns. The representative will refer you to an In-Plan Provider and give you a confirmation number to take to your appointment.

ANNUAL COPAYMENT MAXIMUM FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This plan has a Copayment maximum of $225 per individual and $375 per family per Calendar Year for mental health and substance abuse outpatient office visits. If you reach this Copayment maximum, HNE will reimburse you (or your family) for any other mental health outpatient office visit Copayments you make in excess of the Annual Copayment Maximum. You may only submit your receipts for the medical office visit Copayments at the end of the Calendar Year. You must keep receipts of the Copayments you make as proof that you have reached the Annual Copayment Maximum. Each receipt must indicate the date of service and clearly state that the receipt is from a mental health or substance abuse outpatient office. You will have to continue to pay a Copayment for all other services as indicated on the following chart. **Please note: It is your responsibility to notify HNE once you, one of your Dependents, or your family reaches the Copayment maximum at the end of a Calendar Year.** To obtain reimbursement, send a request in writing to HNE's Member Services Department. Be sure to include your name, address, Member ID number and proof of payment (e.g., provider invoice or receipt only). **Requests for reimbursement must be received by HNE within 90 days of the end of the Calendar Year for which you are seeking reimbursement. For example, a reimbursement request for Copayments that you pay in excess of the Copayment Maximum from January 1st thorough December 31st of 2004, must be received by HNE no later than March 31st, 2005.**

Do all services which include a Copayment count towards the Annual Copayment Maximum?
No. Only Copayments you pay for mental health and substance abuse outpatient office visits count towards the Annual Copayment Maximum for mental health and substance abuse outpatient office visits. There is a separate Annual Copayment Maximum for medical office visits. *(See page 7 for a description of this).*

A. Mental Health Services:
Psychiatrists, psychologists, licensed independent clinical social workers, mental health counselors, or clinical specialists in psychiatric and mental health nursing may provide mental health services. HNE will only cover mental health services when they are Medically Necessary.

HNE will provide coverage as follows:

1. In-hospital care

- In general hospital (no limit): **You Pay… $0**
- In psychiatric hospital (no limit): **You Pay…$0**

Covered alternatives to hospitalization include crisis outpatient visits, day and evening partial hospitalization programs, and emergency respite programs.

2. Outpatient care

- Outpatient services (no limit): **You Pay… $15 per visit**

B. Substance Abuse Services:

HNE will provide coverage for the diagnosis and treatment of substance abuse as follows:

1. Inpatient Services

- Drug or Alcohol Rehabilitation : **You Pay… $0**

Covered alternatives to hospitalization include crisis outpatient visits, day and evening partial hospitalization programs, and emergency respite programs.

HNE covers inpatient detoxification as long as it is Medically Necessary.

2. Outpatient Services

HNE will cover outpatient services including services provided by a physician or psychotherapist who devotes a substantial portion of his or her time to treating drug addicted and intoxicated persons or alcoholics.

- Drug or Alcohol Rehabilitation: **You Pay… $15 per visit**

DENTAL SERVICES

You Pay…

- **$15 per visit in a doctor's office**
- **$75 per outpatient surgical treatment**
- **$50 per visit at an emergency room**
- **$200 per inpatient surgical treatment**

HNE covers only the limited dental services described below. No other dental services are covered.

A. Surgical Treatment of Non-Dental Conditions of the Oral Cavity (Requires HNE's Prior Approval):

This benefit addresses surgical treatment of non-dental conditions, such as lesions, cysts, tumors of the jaw and gums, reduction of a dislocated or fractured jaw or facial bone, and diseases of the mouth.

B. Emergency Dental Care:

HNE covers the initial Emergency dental care needed due to a traumatic injury to sound, natural teeth. You must receive all services, except for suture removal, within 72 hours of injury. Coverage is limited to initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays. HNE does not cover follow-up care or restorative treatment. When you are out of the Service Area, you must report Emergency dental care to HNE if *not* received in a hospital emergency room (for example, at a walk-in clinic or physician's office).

C. Dental Procedures:

HNE covers the following procedures only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely:

- Extraction of seven or more teeth.
- Gingivectomies (including osseous surgery) of two or more gum quadrants.
- Excision of radicular cysts involving the roots of three or more teeth.
- Removal of one or more impacted teeth.

Serious medical conditions include, but are not limited to, hemophilia and heart disease. *Your PCP must authorize, and submit to HNE for Prior Approval, all inpatient and surgical day care admissions.*

WHAT IS COVERED:

HNE covers the following services under the dental benefit:

- Extraction of teeth when needed to avoid infection of teeth damaged in an injury.
- One follow-up visit if treatment results in extraction of teeth.
- Suturing and suture removal.
- Reimplanting and stabilization of dislodged natural teeth.
- Repositioning and stabilization of partly dislodged natural teeth.
- Medication received from the provider.

WHAT IS NOT COVERED:

Services that are not covered under the dental benefit include, but are not limited to, the following:

- Fillings, crowns, implants, caps, or bridges
- Braces
- Root canals
- Dentures
- Periodontics and orthodontics
- Dental treatment of temporomandibular joint syndrome (TMJ). Dental treatment of TMJ is defined as conservative, nonsurgical intervention. This may include, but is not limited to: therapeutic splints, oral appliances, or corrective dental treatments (for example, crowns, bridges, braces and prosthetic appliances).
- Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures
- Removal of non-impacted wisdom teeth

OTHER SERVICES

A. Home Health Care (Requires HNE's Prior Approval): **You Pay… $0**

HNE only covers Medically Necessary home health care services provided in conjunction with a physician-approved home health services plan. A licensed home health agency must provide the services. Care must be provided in the Member's home. (A hospital, skilled nursing, or rehabilitation facility is not considered to be the home.) The home must also be the best place to get Covered Services. Your PCP must arrange all home health care. HNE must approve the appropriateness and Medical Necessity of home health care before services begin. HNE will regularly review these factors.

WHAT IS COVERED:

HNE will cover the following only if they are Medically Necessary:

- Physical, occupational, and speech therapy (the visit limit described in Outpatient Care/Short-term Rehabilitation does not apply when provided as part of the home health benefit).
- Skilled nursing services provided by licensed professionals.
- Durable medical equipment and supplies.
- Medical social services.
- Nutritional counseling.
- Services of a home health aide.

WHAT IS NOT COVERED:

Services that are not covered under the home health benefit include, but are not limited to, the following:

- Disposable supplies such as bandages.
- Custodial Care, unskilled home health care, and homemaking, whether at home or in a facility setting.
- Private duty or block nursing and personal care attendants.
- Long-term care.

B. Hospice Services (Requires HNE's Prior Approval): **You Pay… $0**

HNE covers hospice services provided by a hospice provider for terminally ill Members with a life expectancy of six months or less. Members can continue to receive hospice care for as long as they are certified by their doctor and the hospice director as terminally ill and having a life expectancy of six months or less. After the first six months HNE will request documentation of continued certification. Care may be provided at home or on an inpatient basis. HNE will only cover inpatient care when skilled nursing care is Medically Necessary. Covered Services include: physician services, nursing care, social services, volunteer services, and counseling services.

C. Durable Medical and Prosthetic Equipment (Some items require HNE's Prior Approval):

You Pay… 20% Copayment

HNE covers durable medical equipment (DME), including prosthetic devices and some medical and surgical supplies, when Medically Necessary and ordered by an In-Plan Provider. Some items require HNE's Prior Approval. HNE may decide whether to purchase or rent the equipment. HNE may recover the equipment if your PCP decides you no longer need it or if your membership ends. The cost of the repair and maintenance of covered equipment is also covered. *A referral is not required to obtain durable medical equipment.*

Coverage includes prosthetics, ostomy supplies, and respiratory equipment (including oxygen).
In order to be covered, durable medical equipment must meet the following criteria:

1. It is primarily and customarily used in the treatment of an illness or injury or for the rehabilitation of a malformed body part. (This does not apply to prostheses.)
2. It is able to withstand repeated use.
3. It is primarily intended for activities of daily living. It is not intended primarily for sports-related purposes.
4. It is appropriate for home use (i.e., not hospital or physician equipment).
5. It should not serve the same purpose as equipment already available to the Member. (An exception may be made if the equipment contributes to important clinical decisions and will supply the level of precision needed.)
6. It should not be more costly than a medically appropriate alternative.

HNE will only cover one item of each type of equipment that meets the Member's need. No back-up items are covered.

D. Ambulance and Chair Van Services: **You Pay… $25 per day per Member**

Member is responsible for one Copayment per day. HNE will cover ambulance and chair van services as follows:

- **Emergency Transportation** - HNE will cover transportation in a medical Emergency (i.e., where a prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm). HNE will cover transportation services from the place where a person is injured or stricken by disease to the nearest hospital where treatment can be given. HNE will also cover transport from one hospital to another hospital when the first hospital does not have the required services and/or facilities to treat the Member.
- **Air Ambulance** - HNE covers air ambulance services in the case of a life threatening Emergency or when otherwise pre-authorized by HNE.
- **Non-Emergency Transportation (requires Prior Approval)**- HNE will cover ambulance or chair van services for a Member from a hospital setting to their home, or to a skilled nursing facility, if the Member cannot be safely or adequately transferred without endangering their health. All non-emergency transportation services must be pre-approved by HNE.

WHAT IS NOT COVERED

- HNE does not cover transportation by ambulance or by chair van for patient convenience or for non-clinical reasons.
- HNE does not cover transportation to or from a doctor's office, clinic, or other place for medical care that can be planned ahead of time.

E. Reconstructive or Restorative Surgery: **You Pay… $200 per inpatient admission**
$75 per outpatient surgery

HNE covers reconstructive surgery to repair, improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or a previous surgical procedure or disease.

HNE will provide coverage, following a mastectomy, for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses (subject to the 20% coinsurance for DME and prosthetics).
- Any physical complications resulting from the mastectomy, including lymphedemas.

Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

The Plan will not cover reconstructive or restorative surgery for dental procedures, procedures for cosmetic purposes only or treatment for complications resulting from non-covered cosmetic procedures.

F. Kidney Dialysis: **You Pay… $0**

HNE covers kidney dialysis on an inpatient or outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payor for dialysis. You must also pay any Medicare premium.

WHAT IS NOT COVERED:

The following are not covered under the kidney dialysis benefit:

- Charges to acquire power, water, and sanitary waste disposal systems for attaching a dialyzer or home hemodialysis.
- The cost of electricity or water used in the dialysis procedure.
- Compensation for anyone in assisting in the dialysis procedure.
- Expenses incurred in the installation of a dialyzer or deionizer which are not essential to its operation or installation.

G. Human Organ Transplants (Requires HNE's Prior Approval): **You Pay… $200**

WHAT IS COVERED:

HNE covers the following organ transplants when Medically Necessary:

- Autologous bone marrow transplants for the following diagnoses:
  - acute leukemia in remission;
  - resistant non-Hodgkin's lymphomas;
  - advanced Hodgkin's disease;
  - recurrent or refractory neuroblastoma.
- Allogeneic or autologous bone marrow transplants for multiple myeloma, aplastic anemia, leukemia, severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and cases of metastatic breast cancer which meet the coverage eligibility requirements established by the Massachusetts Department of Public Health. HNE does not cover bone marrow or stem-cell harvest or rescue and related treatments, except for these diseases.
- Cornea transplant. Contact lenses following a cornea transplant are covered for up to one year, if Medically Necessary.
- Heart transplant.
- Heart/lung transplant.
- Lung transplant.
- Kidney transplant.
- Liver transplant.

- Human leukocyte antigen testing or histocompatibility testing for a Member when necessary to establish such Member's bone marrow transplant donor suitability. HNE will cover the costs of testing for A, B, or DR antigens, or any combination thereof.

In the case of bone marrow transplants, if a covered bone marrow transplant is not available from an In-Plan Provider, HNE will pay for services rendered by an Out-of-Plan Provider. You must get Prior Approval before receiving services from an Out-of-Plan Provider. In the case of covered human organ transplants, where the Member is the recipient of a human organ, HNE will cover the services for the donor *only* when HNE has proof that the services are not covered under any other health insurance contract. When an HNE Member is the donor, HNE will cover services for this Member only if the recipient's health plan will not cover the services.

WHAT IS NOT COVERED:
The following are not covered under the transplant benefit:
- Human organ transplants that are not listed above or that are experimental or unproven.
- Transportation and lodging expenses for a Member and/or his or her family.
- Artificial or animal to human organ or tissue transplant.

H. Nutritional Support (Requires HNE's Prior Approval): **You Pay… $0**
HNE covers specific nutritional support as described below.

WHAT IS COVERED:
HNE will cover the following when Medically Necessary and ordered by an In-Plan Doctor:
- Nutritional support, including enteral tube feedings, when the Member has a permanent impairment involving the gastrointestinal tract that prevents adequate oral nutritional intake.
- Parenteral nutrition and total parenteral nutrition.
- Special medical foods that are taken orally and prescribed for:
  - Phenylketonuria (PKU).
  - Tyrosinemia.
  - Homocystinuria.
  - Maple syrup urine disease.
  - Propionic acidemia.
  - Methylmalonic acidemia in a Dependent child.
  - Protection of an unborn fetus of a pregnant Member with PKU.
- Non-prescription enteral formulas for home use that are Medically Necessary for the treatment of malabsorption caused by:
  - Crohn's disease.
  - Ulcerative colitis.
  - Gastroesophageal reflux.
  - Gastrointestinal motility.
  - Chronic intestinal pseudo-obstruction.
  - Allergic enteropathy, including allergic colitis.
- Low protein food products for inherited disease of amino acids and organic acids. *Coverage for low protein food products will not exceed $2,500 per Member per Calendar Year.*

WHAT IS NOT COVERED:
- Dietary supplements, specialized infant formulas (such as Nutramigen, Elecare, and Neocate), vitamins and/or minerals taken orally to replace intolerable foods, supplement a deficient diet, or provide alternative nutrition for conditions such as hypoglycemia, allergies, obesity, and gastrointestinal disorders. These products are not covered even if they are required to maintain weight or strength.

I. Cardiac Rehabilitation: **You Pay… $15 per visit**

HNE will cover the multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease. HNE will cover such care when received in a hospital or other setting, and when the care meets standards issued by the Commissioner of Public Health. Such standards will include, for example, outpatient treatment, if the treatment is started within 26 weeks after the diagnosis of the disease.

J. Nurse Anesthetists and Nurse Practitioners: **You Pay… $15 per visit**

HNE will cover services provided by a certified registered nurse anesthetist or nurse practitioner that participates with the Plan, if the following conditions are met:

1. The service rendered is within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice by the Board of Registration in Nursing; and
2. HNE covers the identical services when rendered by other licensed providers of health care.

K. Scalp Hair Prostheses (Wigs): **You Pay… All costs over $350**

HNE will cover scalp hair prostheses (wigs) worn for hair loss due to the treatment of any form of cancer or leukemia. HNE will reimburse the Member up to $350 toward the cost of the wig. This benefit is limited to $350 per Calendar Year. You must send your request for reimbursement to the HNE Member Services Department. The request must include proof of payment and a written statement from your physician that the wig is Medically Necessary.

L. Coronary Artery Disease/Change of Heart Program: **You Pay…10% of cost of program**

Coverage for this program will be provided to Members with documented coronary artery disease, diabetes or high cholesterol to help participants reduce disease risk factors through lifestyle changes. *The program must be authorized by your PCP.*

M. Hearing Aids: **You Pay…See below**

HNE will provide coverage for hearing aids at 100% for the first $500 and 80% coverage for the next $1,500 per person every two Calendar Years.

N. Nutritional Counseling: **You Pay…$15 per visit**

HNE will cover up to a maximum of two outpatient visits per Calendar Year for nutritional counseling.

O. Hormone Replacement Therapy: **You Pay…applicable prescription drug Copayment**

HNE covers hormone replacement therapy services for peri- and postmenopausal women.

P. Cancer Clinical Trials

HNE covers patient care items and services provided in a cancer clinical trial, as long as:

- The trial meets the definition of a "qualified clinical trial" as contained in Massachusetts General Laws Chapter 176G, section 4P.
- The service or item:
  - is consistent with the usual and customary standard of care;
  - is consistent with the study protocol for the clinical trial; and
  - would be covered if the Member did not participate in the clinical trial.

WHAT IS NOT COVERED:

- An investigational drug or device paid for by the manufacturer, distributor or provider of the drug or device.
- Non-health care services that a Member may be required to receive as a result of being enrolled in the clinical trial.
- Costs associated with managing the research associated with the clinical trial.
- Costs that would not be covered for non-investigational treatments.

- Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the clinical trial.
- The costs of services which are inconsistent with widely accepted and established national or regional standards of care.
- The costs of services which are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements, and other services which are typically covered but which are being provided at a greater frequency, intensity or duration.
- Services or costs that HNE does not cover.

Q. Special Programs and Discounts:

By joining HNE, you may have access to special programs and discounts, such as discounts on health education classes, chiropractors, acupuncture, and massage therapy. Please contact HNE for the most current listing of all of HNE's special programs and discounts, as these programs and discounts may change from time to time.

SECTION 4 – EXCLUSIONS AND LIMITATIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- Not all care is covered.
- Some services that are covered have specific limitations.

HNE excludes all services, supplies, and other items of care not specifically included in this Member Handbook. Coverage is subject to the terms and conditions of this Member Handbook. For example, services must be Medically Necessary. HNE does not limit or exclude coverage for pre-existing conditions. **Please also see the descriptions of individual benefits for services that are limited or partly excluded.**

HNE excludes the following services and supplies:

1. All medical, hospital, or other health care services or supplies provided by an Out-of-Plan Provider, unless approved by an In-Plan Doctor *and* HNE in accordance with HNE policies and rules. HNE *will* cover services or supplies rendered by Out-of-Plan Providers in cases of an Emergency medical condition. See "Emergency Care" in Section 2.
2. Any services that are the legal liability of Workers' Compensation Insurance or other third party insurer.
3. Any services provided by the Veterans Administration for service-connected disabilities to which Members are legally entitled and for which facilities are reasonably available.
4. Services authorized to be provided under MGL Chapter 71B in Massachusetts (referred to as "Chapter 766") or Section 10-76A-d of the General Statutes in Connecticut. These services include, for example:
   - Adaptive physical education.
   - Physical and occupational therapy.
   - Psychological counseling.
   - Speech and language therapy.
   - Transportation.

   Members who believe that their child may be handicapped (physical disability, mental retardation, learning problem, or behavioral problem) should seek a Chapter 766 or a Section 10-76A-d evaluation. Members must make appropriate and reasonable efforts to obtain benefits available under state law.
5. Eyeglasses.
6. Arch supports, foot orthotic devices, and corrective shoes except as required by law.
7. Chiropractic care.
8. Routine foot care, which includes but is not limited to:
   - Cutting or removal of corns and calluses, plantar keratosis
   - Trimming, cutting and clipping of nails
   - Treatment of weak, strained, flat, unstable or unbalanced feet
   - Other hygienic and preventive maintenance care considered self-care (i.e. cleaning and soaking the feet, and the use of skin creams to maintain skin tone)
   - Any service performed in the absence of localized illness, injury or symptoms involving the foot

   HNE will cover routine foot care if you are a diabetic.
9. Sperm or egg banking not connected with approved Infertility treatment for an active cycle.
10. Gender reassignment operations and treatments.

11. Services rendered outside the HNE Service Area, when the Member could have foreseen the need for such services before leaving the Service Area. This exclusion will apply unless HNE has approved such services in advance.
12. Travel, transportation and lodging expenses for a Member and/or a Member's family as a course of treatment or to receive consultation or treatment.
13. Medical expenses incurred in any government hospital or facility or for services of a government doctor or other government health professional.
14. Medical care that HNE's Medical Director determines is experimental, investigational, or not generally accepted in the medical community. Experimental means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by, among other sources, formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing or treatment.
15. Acupuncture.
16. Holistic treatments.
17. Alternative medicine.
18. Care or treatments provided by family members.
19. Weight control programs.
20. Dietary supplements.
21. Provider charges for shipping or copying medical records or for failing to keep an appointment.
22. Specialty clothing appropriate to specific medical conditions.
23. Cosmetic or beautifying surgeries, procedures, drugs, services, or appliances. See page 32.
24. Services received after the date that coverage ends.
25. Items not listed or listed as "not covered" on the DME and medical and surgical supplies list.
26. Special duty or private duty nursing and attendant services.
27. Elective treatment or surgery not required by your medical condition, according to the judgment of the Plan.
28. Treatment by telephone.
29. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training and/or educational therapy for learning disabilities, or other educational services such as educational testing.
30. Services and treatment not in keeping with national standards of practice, as determined by the Plan's Medical Director or his/her designees, including but not limited to: nutritional based therapies, non-abstinence based substance abuse care, crystal healing therapy, rolfing, regressive therapy, EST, and herbal therapy.
31. Acne-related services, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin. (Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.)
32. Services or supplies which are furnished or paid for, or with respect to which payments are actually provided, under any law of a government (national or otherwise) by reason of the past or present service of any person in the armed forces of a government.
33. Services or supplies, other than those referred to in item 32 above, which are paid for, or with respect to which benefits are actually provided, under any law of a government (national or otherwise) except where

such payments are made or such benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.

34. Contact lenses are covered only for: cataract after extraction, keratoconus; aphakia, or following a cornea transplant, for up to one year, if Medically Necessary. A lens applied as a bandage lens following an eye injury or to treat a diseased cornea is covered.
35. Nutritional supplements except as described under "Nutritional Support" in Section 3 of this Agreement.
36. ALCAT test for food sensitivity.
37. Diagnostic tests analyzed in functional medicine laboratories such as Genova Diagnostics.
38. Fees to a donor or program for donation of sperm/egg(s).
39. Laser treatment for psoriasis.
40. Laser vision correction surgery.
41. Neurobiofeedback.
42. Orthoptics.
43. Reduction mammoplasty for male gynecomastia.
44. Tinnitus masker.
45. Experimental implants are not covered. Non-experimental implants are covered only when Medically Necessary due to a functional defect of a bodily organ and when the implant will serve to restore full normal function. (Note: This refers to implants. Coverage and exclusions for transplants are described in Section 3.)
46. INJEX™/ROJEX™ needle-free system.
47. Growth factor mediated lumbar spinal fusion devices such as the InFUSE™ bone graft/LT-CAGE™ lumbar tapered fusion device.
48. Extracorporeal Shock Wave Therapy (ESWT) for Chronic Plantar Fasciitis.
49. Sclerotherapy, joint and ligamentous injections (Prolotherapy).
50. Sclerotherapy for non-symptomatic varicose veins.
51. Educational service or testing, except services covered under the benefit for early intervention services described in Section 3 – Covered Benefits.
52. Vocational rehab, including job retraining, or vocational and driving evaluations focused on job adaptability, or therapy to restore function for a specific occupation.
53. LapBand® adjustable gastric banding.
54. Dermatoscopy for detection of melanoma.

COSMETIC SERVICES

HNE does not cover cosmetic services, follow up treatment for cosmetic services, or treatment for complications resulting from cosmetic procedures. The primary purpose of cosmetic or beautifying surgeries, procedures, drugs, services, or appliances is to improve, alter or enhance appearance or self image. They are not necessary to maintain or restore an essential bodily function, or they are performed for psychological or emotional reasons.

Below are some examples of procedures that are considered cosmetic in nature and are not covered:

- Botox injections for cosmetic purposes
- Breast implants
- Chemical exfoliation for acne
- Chemical Peel
- Chin implant (Not covered except for correction of deformities that are secondary to disease, injury or congenital defect.)

- Collagen implant (e.g. Zyderm)
- Correction of diastsis recti abdominis
- Dermabrasion for removal of acne scars
- Earlobe repair to close a stretched or torn ear pierce hole
- Electrolysis for hirsutism
- Excision of excessive skin on thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad or other areas
- Excision or repair of keloid
- Grafts, fat
- Otoplasty
- Reduction of labia minora
- Removal of spider angiomata
- Rhytidectomy
- Salabrasion
- Scar revision
- Suction assisted lipectomy

This list is not exhaustive, and any procedure considered cosmetic in nature will be excluded.

SECTION 5 – CLAIMS AND UTILIZATION MANAGEMENT PROCEDURES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- Some procedures require HNE's Prior Approval. Procedures requiring Prior Approval are listed in this section.
- HNE also performs retrospective and concurrent reviews as part of its Utilization Management program.

UTILIZATION MANAGEMENT PROGRAM

The purpose of HNE's Utilization Management program is to review certain claims to determine if they are Covered Benefits and if they are Medically Necessary and appropriate. There may be times when a service is not approved. When this occurs, coverage for the services may be denied. A utilization management denial may be made only on the basis of whether it is Medically Necessary or appropriate or if it is not a Covered Benefit under the Plan. HNE knows that there is a risk of under-utilization of necessary health care services. It therefore states that:

- HNE's utilization management programs have been designed to ensure that medical decision-making is based on the appropriateness of care and services and the existence of coverage.
- HNE encourages all clinicians and administrative staff who are involved in utilization management review to work collaboratively to help Members obtain access to appropriate health care resources.
- HNE does not provide compensation or other financial incentive or reward to its In-Plan Providers or staff who conduct utilization management review that is based on the quantity or type of denial decisions rendered.

PROCEDURES THAT REQUIRE HNE'S PRIOR APPROVAL

In order to obtain coverage for certain services and procedures, your Primary Care Physician or treating In-Plan Provider is required to get HNE's Prior Approval. Your Primary Care Physician or treating In-Plan Provider must get HNE's Prior Approval if you plan to have any of the following services or procedures:

- All elective admissions.
- Blepharoplasty.
- Certain durable medical equipment (contact HNE for specific items).
- Chair van services and non-emergency transportation by ambulance.
- Cochlear implants.
- Computerized Tomography (CT) scans.
- Diabetic teaching.
- Female reduction mammoplasty.
- Growth hormone, Remicade, and a select listing of prescription medications (contact HNE for specific medication information).
- Hospice services.
- Human organ transplants.
- Infertility treatment (Prior Approval is required for Assisted Reproductive Technologies [ARTs] such as IVF, GIFT, ZIFT, ICSI, donor egg, FET services and related ART medications. Prior Approval is not required for evaluation, artificial insemination/Intra-Uterine Insemination (AI/IUI) services and related AI/IUI medications.)
- Intravenous Immunoglobulin (IVIg) therapy.
- Laser-assisted uvulopalatoplasty or uvulopalatopharyngoplasty (corrective surgery of the palate, uvula, or related structures).
- Magnetic Resonance Angiogram (MRA).

- Magnetic Resonance Imaging (MRI).
- Mandibular advancement device for treatment of obstructive sleep apnea.
- Neuropsychological testing. (For Prior Approval, call HNE's Behavioral Health Triage Unit at 800-842-4464 ext. 5028)
- Nutritional Support.
- Oral surgery for treatment of non-dental conditions.
- Outpatient hyperbaric oxygen therapy.
- Outpatient mental health and substance abuse services.
- Positron Emission Tomography (PET) scans.
- Prosoba column.
- Pulmonary rehabilitation.
- Rhinoplasty.
- Self-monitoring of anti-coagulant therapy.
- Services from Out-of-Plan Providers.
- Skilled home care services, including home infusion; perinatal monitoring; skilled nursing care; and home physical, occupational, and speech therapy.
- Sperm storage.
- Surgical management of morbid obesity.
- Any other services listed in this Member Handbook that indicate that Prior Approval is necessary.

HNE will notify you of any changes to this list through our Member newsletter or through a direct mailing.

Prior Approval Process
To get HNE's Prior Approval, have your treating In-Plan Provider send a Prior Approval Request Form or, for Infertility treatment, an Infertility Prior Approval Request Form, to HNE's Health Services Department. In reviewing these requests, HNE may consider whether the service:

- Is a Covered Benefit or Service
- Is Medically Necessary
- Is being provided in the appropriate setting
- Follows generally accepted medical practice
- Is available within the HNE network
- Meets HNE's clinical criteria for coverage

Your treating In-Plan Provider may also contact HNE by phone. This should be done at least seven days before the date of your procedure. HNE will make a decision on your request within two working days of receiving all necessary information. If HNE approves coverage for your service or procedure, we will inform the provider rendering the service by phone within 24 hours. We will notify you and that provider in writing within two working days thereafter.

If HNE cannot approve coverage based on the information received, we may ask for more information. If the additional information does not justify the service or procedure, we will inform the provider who is rendering the service by phone within 24 hours that our criteria have not been met. If your doctor disagrees with our utilization review decision, your doctor may request a case discussion with an HNE physician reviewer. This discussion may result in the reversal of HNE's decision. Your doctor may also request a reconsideration of our decision from a clinical peer reviewer. This reconsideration will be conducted between your doctor and the clinical peer reviewer within one working day of the request for reconsideration. If you are still dissatisfied, you (or your doctor on your behalf) may request a formal review. (See Inquiries and Grievances Section.)

If you have requested a service that requires HNE's Prior Approval and would like to know the status or outcome of the review, you may call 800-310-2835. You may also call HNE's Health Services Department if you would like a copy of the clinical criteria HNE uses to make its determinations.

To find out if a particular durable medical equipment item requires Prior Approval, please call Member Services at the number at the bottom of this page.

If HNE reviews a procedure or hospital admission, it does not mean that the Plan will cover all charges. Benefit determinations will be made by HNE according to all the terms of this Member Handbook. Benefits for treatment, services, or supplies that are not covered under this Member Handbook may be denied.

CONCURRENT REVIEW PROCEDURES

For certain procedures and services, such as inpatient hospital stays and ongoing courses of treatment, HNE may pre-approve the service or procedure. However, HNE will then review the Medical Necessity and appropriateness of the procedure during your stay or during the course of your treatment. This is called "concurrent review." If, based on this concurrent review, HNE decides to terminate or reduce your coverage, we will notify you in writing prior to the reduction or termination of the service. If you decide to appeal our decision, HNE will continue to cover the services until your appeal is completed.

Any request to extend the course of treatment involving urgent care will be decided and communicated within 24 hours after receipt (provided that the request is made at least 24 hours prior to the expiration of the course of treatment).

RETROSPECTIVE REVIEW PROCEDURES

Retrospective review is an initial review of any service that was already received by a Member. If HNE determines that the service was not Medically Necessary or appropriate, HNE may deny the claim for benefits. HNE will notify you of any claims denied on this basis within thirty (30) days of HNE's receipt of the claim.

SECTION 6 – INQUIRIES AND GRIEVANCES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- If you have a complaint about the care you have received or about HNE's service, we want to know.
- If HNE has denied your claim or request for service, you have the right to appeal.

INQUIRY PROCESS

An "inquiry" is any communication that requests redress of an HNE action, omission, or policy. If you have an inquiry:

- Please call us. We will review your inquiry and respond by phone or letter within three business days.
- We will then ask you if you are satisfied with our response. If you tell us that you are not satisfied, we will offer to start a review of your complaint through the internal grievance process.
- We can start this review process over the telephone. If you choose not to start a grievance during our call, we will send you a letter to explain your right to have your inquiry processed as an internal grievance. If your concern is about a provider or provider office, HNE may share the details of your concern with that provider or office.

INTERNAL GRIEVANCE PROCESS

This section describes key terms, how to submit a grievance, and what to expect from HNE. A "grievance" is any oral or written complaint about any aspect or action of HNE relative to the Member or about quality of care or Plan administration. Grievances also include benefit appeals and appeals of Adverse Determinations or clinical appeals. The following chart describes the different types of grievances and the time frames within which HNE must respond to your grievance. Please note that the time limits in this section may be waived or extended if both HNE and the Member agree. All time frames begin on the date that HNE receives your grievance or on the day immediately following the three-business day period for processing inquiries, if HNE was unable to address your inquiry within that time. Any grievance not properly acted on by HNE within the specified time limits (which include any agreed-upon extensions) will be resolved in favor of the Member.

Overview: Grievances and Decision Time Frames		
Type of Grievance	**Example**	**HNE will respond within:**
Complaint	An inquiry that is not resolved to a Member's satisfaction, or a plan policy or procedure that causes concern to a Member.	30 business days
Benefit Appeal	Appeal of a service or request that is denied as "not a covered benefit" because it is excluded from coverage by your plan.	
Pre-Service	Appeal of a benefit denial for a service you have not received yet.	30 calendar days
Post-Service	Appeal of a benefit denial for a service you have already received.	30 business days
Clinical Appeal	Appeal of a decision that was based upon a review of information provided, to deny, reduce, change or end coverage of a health service for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.	
Pre-Service	Appeal of a clinical denial for a service you have not received yet.	30 calendar days

Overview: Grievances and Decision Time Frames		
Type of Grievance	**Example**	**HNE will respond within:**
Post-Service	Appeal of a clinical denial for a service you have already received.	30 business days
Expedited Appeal	Appeal of a clinical denial for a service that your doctor feels is urgent, for continued coverage of a hospital stay or for a Member with a terminal illness.	72 hours or before you are discharged from the hospital
Appeal for a terminally ill Member	See the complaint and benefit appeal examples above.	5 business days

SUBMITTING YOUR GRIEVANCE

You must submit your grievance within 180 calendar days after you receive notice that HNE has denied your claim for services. You may submit your grievance by telephone, in person, by mail, or by electronic means. Please include the following information:

- ✓ Member ID number.
- ✓ Daytime telephone number.
- ✓ Detailed explanations of your grievance and any applicable documents related to your grievance, such as copies of medical records or billing statements.
- ✓ Specific resolution you are requesting.
- ✓ Any other documents that you feel are relevant to the review.

You may contact us by:

Mail: Health New England
Complaint and Appeals Department
One Monarch Place
Springfield, MA 01144-1500

Fax: 413-233-2685
(For complaints and appeals only. If you are faxing information on a billing issue, please fax to Member Services at 413-233-2655.)

Telephone: 800-310-2835 or 413-787-4004

Electronically: To find out how, please call HNE Member Services at the number at the bottom of this page.

Your authorized representative may also submit the grievance on your behalf. If you submit a grievance by mail, HNE will send a written acknowledgement of receipt of your grievance within five business days. If you submit your grievance orally, HNE will put your grievance in writing and send a copy to you within 48 hours. If your grievance is about a clinical denial, we may ask you to sign a form releasing your medical or treatment information to HNE.

HNE will fully investigate the substance of all complaints and appeals. All appeals will be reviewed by a person or persons who were not involved in the initial decision nor subordinates of anyone involved in the initial decision.

Complaints and Benefit Appeals
A person knowledgeable about the subject matter of your complaint or benefit appeal will review it and issue a decision based on all available information.

Appeals of Clinical Denials
A practitioner who is actively practicing and who was not involved in the initial decision will review your appeal. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal.

If HNE has asked you to agree in writing to the release of your medical records, we will also ask you to agree, in writing, that we may take up to 30 business days after you return the release to issue a decision. If you choose not to sign the release, or if HNE does not receive a signed release within 30 calendar days of our receipt of your grievance, we may, at our discretion, issue a decision without review of some or all of your medical records.

If HNE does issue a decision without review of all your medical records, HNE may offer you a reconsideration. HNE will only offer this if, through no fault of your own, relevant medical information was received too late to review within the 30-business day limit or was not received but is expected to become available within a reasonable time period following the written resolution. If HNE offers you a reconsideration based on these facts, HNE will agree in writing on a new time period for review, but in no event greater than 30 business days from the agreement to reconsider. The time period for requesting external review will begin on the date of the resolution of the reconsidered grievance.

If you do not agree with HNE's decision, in many cases, you have a right to an external review. See "External Appeals Process" later in this section.

If a grievance is filed concerning the termination of ongoing coverage or treatment that HNE previously approved, HNE will continue to cover the disputed service or treatment through the completion of the internal grievance process regardless of the final decision. HNE will not continue to cover medical care that was terminated pursuant to a specific time or episode-related exclusion.

Expedited Review Process: For Immediate or Urgently Needed Services
HNE will "expedite" the review of an appeal for coverage of services that are immediate or urgently needed. A practitioner who is actively practicing and who was not involved in the initial decision will review your appeal. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal.

If you are an inpatient in a hospital, HNE will make a decision on your grievance before you are discharged from the hospital. In all other cases, HNE will make a decision on your grievance and notify you and your provider within 72 hours of receipt of your request. Written confirmation of this decision will be sent to you within two business days after this notification is made.

For services or durable medical equipment that, if not immediately provided, could result in serious harm to you, HNE will reverse its decision to deny coverage within 48 hours (or sooner in some cases) pending the outcome of the grievance process. For a reversal to occur within 48 hours, your doctor must certify that:

1. The service or durable medical equipment at issue in your appeal is Medically Necessary.
2. The denial of coverage would create a substantial risk of harm to you.
3. Such risk of serious harm is so immediate that the provision of such services or DME should not await the outcome of the normal grievance process.

The reversal will last until the appeal is decided.

Expedited Review Process: For Members with a Terminal Illness
A person knowledgeable about the subject matter will review a complaint or benefit appeal. A practitioner who is actively practicing and who was not involved in the initial decision will review clinical appeals. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal. HNE will make a decision on your grievance within five business days of receipt. If a Member with a terminal illness appeals a decision of an immediate or urgently needed service, HNE will make a decision on your grievance within 72 hours of the receipt of your grievance.

If HNE continues to deny coverage or treatment, you have the right to request a conference. HNE will schedule a conference within 10 business days of receipt of your request. If your doctor, after consulting with HNE's Medical Director, decides that the effectiveness of the proposed service or treatment would be materially reduced if it is not provided at the earliest possible date, HNE will schedule the hearing within five business days. You and/or your authorized representative may attend the conference. HNE will authorize its representative at the conference to decide your grievance.

OUR WRITTEN RESPONSE

HNE's written response to your grievance will:
- Include the specific reason for the decision.
- Identify the specific information on which the decision was based.
- Reference and include the specific plan provisions on which the decision was based.
- Specify alternative treatment options covered by HNE, if any.
- Notify you of the process for requesting an external review or, where applicable, an expedited external review.

In addition, for clinical appeals, the written response will also:
- Include a substantive clinical reason that is consistent with generally accepted principles of professional medical practice.
- Discuss your presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet HNE's medical review criteria.
- Reference and include applicable clinical practice guidelines and review criteria.

You also have the right to request copies, free of charge, of all documents, records or other information relevant to your appeal.

EXTERNAL APPEAL PROCESS

If HNE has denied your clinical appeal and you do not agree with HNE's decision, you can ask for an external appeal. To do so, you need to file a written request with the Department of Public Health, Office of Patient Protection. HNE will provide you with the necessary filing forms when it notifies you of its final decision. You can also obtain the necessary forms by calling OPP or accessing its web site. The fee for filing an appeal is $25. This fee may be waived by OPP if it determines that the payment of the fee would result in an extreme financial hardship to the Member. Information on contacting OPP is at the end of this section. You must submit the request within 45 days after you receive HNE's final decision on your appeal.

The OPP will screen appeal requests. The OPP screening determines whether the request:
- Complies with OPP's requirements for external review requests (such as the $25 filing fee).
- Involves a service or benefit that has been explicitly excluded from coverage.
- Is the result of a final Adverse Determination.

Requests that pass the screening are sent to an independent review panel chosen by OPP. If the service or treatment you are requesting is a Covered Benefit, the appeal panel will decide if it is Medically Necessary. The panel will notify you and HNE of its decision within 60 business days of receipt of the request for review, unless it determines

that it needs additional time. The panel may extend the time by an additional 15 days. Your doctor can ask the panel to decide more quickly (an expedited review). If the panel agrees, it will decide within five business days. The decision of the review panel is final and binding.

If the subject of the external review involves the termination of ongoing services, you may ask the external review panel to continue coverage for the terminated service while the review is pending. The review panel may allow your request if it determines that substantial harm to your health may result without such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage will be at HNE's expense regardless of the final external review decision.

MASSACHUSETTS OFFICE OF PATIENT PROTECTION

Massachusetts has set up an Office of Patient Protection within the Department of Public Health. This office will accept consumer complaints and manage the external review process described above. The following information is also available from the Office of Patient Protection:

- A list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by HNE.
- The percentage of doctors who voluntarily and involuntarily ended their participation with HNE during the previous Calendar Year for which such data has been compiled and the three most common reasons for voluntary and involuntary disenrollment.
- The percentage of premium revenue HNE spends for health care services for the most recent year for which data is available.
- A report detailing, for the previous Calendar Year, the total number of filed grievances, grievances that were approved internally, grievances that were denied internally, grievances that were withdrawn before resolution, and external appeals pursued after exhausting the internal grievance process and the resolution of all such appeals.

How to contact the Office of Patient Protection:

Toll-free telephone:	800-436-7757
Fax:	617-624-5046
Web site:	www.state.ma.us/dph/opp

SECTION 7 – ELIGIBILITY

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- To be eligible as a Member you normally must live in the HNE Service Area.
- Eligibility depends on the terms of the Group Insurance Commission contract.
- Dependent coverage normally ends at age 19.
- HNE may require reasonable evidence of eligibility from time to time.

The Group Insurance Commission determines the eligibility of any person, whether it be an employee, retired employee, dependent of an employee, dependent of a retired employee, surviving spouse of a deceased employee or retiree or surviving dependent of a deceased employee, retiree or surviving spouse. HNE may require proof of eligibility from time to time.

RESIDENCY REQUIREMENT

To be eligible for coverage under the Plan, you must live, and maintain a permanent residence, within the HNE Service Area for at least nine months per year. This requirement does not apply to a Dependent child who is enrolled as a full-time student.

SUBSCRIBERS

To be eligible as a Subscriber, you must meet the Group Insurance Commission's eligibility rules and be either:

- An eligible employee of the Group.
- A retired state employee, or a participant in the Group Insurance Commission's Retired Municipal Teacher Program and Elderly Governmental Retiree Program, who is not eligible for Medicare.
- A Qualified Beneficiary as defined by applicable laws and regulations concerning continuation of health insurance coverage.
- A surviving spouse of an eligible employee or retiree.

DEPENDENTS

To enroll as a Dependent, you must meet the GIC's eligibility rules and be either:

- The legal (married) spouse of the Subscriber.
- In some cases, the divorced spouse of the Subscriber, as described in the "Divorced Spouses" section below.
- A child of the Subscriber or the Subscriber's spouse who meets *all* of the following criteria:
  - is unmarried,
  - lives with the Subscriber or the Subscriber's spouse, and
  - is less than 19 years old.
- An adopted child of the Subscriber or the Subscriber's spouse who meets *all* of the requirements in the third bullet, and as described in the "Adopted Dependents" section below.
- A child for whom the Subscriber has been named legal guardian and who meets *all* of the requirements in the third bullet. The Subscriber must enroll the child as a Dependent within 31 days after being named legal guardian by the court. Children under legal guardianship will normally be covered from the date the Subscriber was named legal guardian by the court.

- A child of an eligible Dependent who meets *all* of the criteria listed in the third bullet, until the parent is no longer a Dependent.
- An unmarried child of the Subscriber who is under 19 years of age and for whom the Subscriber is required by a Qualified Medical Child Support Order to provide health coverage.
- A student Dependent, as described in the "Student Dependents" section below.
- A disabled Dependent, as described in the "Disabled Child Dependents" section below.

ADOPTED DEPENDENTS

When can I enroll a child whom I have adopted or am trying to adopt?
The Subscriber may enroll a child that he/she has adopted within 31 days of the date of filing the adoption petition. In all other cases, HNE will cover the child from the date that the child has been placed for adoption in the Subscriber's home by a licensed placement agency. The Subscriber must enroll the child as a Dependent within 31 days of the date of placement.

STUDENT DEPENDENTS

What happens when my child turns 19?
When a Dependent child turns 19 years old, coverage ends at the end of the Dependent child's birthday month. Prior to a Dependent child reaching age 19, a letter is sent to your home address from Health New England. The letter informs you that your Dependent's coverage will end at age 19. The letter also requests information from you which may allow your Dependent to remain covered under the family contract. If your Dependent son or daughter is enrolled as a full-time student at an accredited school, such as a college, junior college, or trade school, he or she is eligible to continue coverage. *In order to obtain such coverage beyond the age 19 termination date, you must contact the Group Insurance Commission and fill out an application with the Commission*. Thereafter, twice each Calendar Year, during February and September, an affidavit letter will be sent to your home address to verify your Dependent student's status. The affidavit letter must be executed by you and returned to HNE within the stated time. If an affidavit letter is not returned to HNE within the stated time, HNE will assume that the Dependent is no longer a full-time student and no longer eligible to remain part of a family contract. The student will then lose HNE coverage as of the last day of the month in which the Dependent last attended school or graduated. A letter of termination will be sent to your home address and a copy of the termination letter will be provided to the Group Insurance Commission.

If the student Dependent continues to meet all other Dependent eligibility criteria his or her coverage will be continued until he or she reaches age 24. Full-time students between ages 19 and 24 may be included in family coverage after their application and confirmation of their status by their educational institution is approved by the Group Insurance Commission.

Student coverage ends at the end of the month in which the student ceases to have full-time student status, or marries.

Students age 24 and older must pay for full-cost individual coverage, with no contribution from the Commonwealth of Massachusetts.

What happens if my son or daughter goes to a school out of the HNE Service Area? Will HNE still cover him/her?
If your child goes to school outside the HNE Service Area, HNE will cover him or her for care received outside the HNE Service Area only in an Emergency. **He or she must get all follow-up care and routine care from In-Plan Providers in the Service Area.**

What happens if my Dependent child marries?
When your Dependent child marries, family group coverage ends for him or her at the end of the month in which the marriage takes place.

DISABLED CHILD DEPENDENTS

What happens if my child is disabled when he or she turns 19?
Arrangements may be made to continue coverage for physically or mentally handicapped children age 19 and older who are incapable of self-support at age 19. *Application must be made to the Group Insurance Commission to obtain this coverage. Coverage is subject to Group Insurance Commission approval.* Handicapped children receive their own identification numbers but continue to be considered part of the family policy when benefits are determined.

DIVORCED SPOUSES

What happens if I divorce? Is my former spouse still eligible for coverage?
You and your former spouse should contact the Group Insurance Commission within 60 days of the date your divorce becomes final to determine your rights to group coverage.

Under Massachusetts state law, if you are divorced and have not remarried, your former spouse is eligible to continue as a Dependent on your policy, unless your divorce judgment specifically states otherwise or unless he or she lives outside the HNE Service Area. Your former spouse may continue as a Dependent on your policy until the earlier of either of the following:

- The time specified in your divorce judgment
- You or your former spouse remarry

If your former spouse moves out of the HNE Service Area, he or she will no longer be eligible for Health New England coverage.

In addition, Federal law permits continuation of group health care coverage for divorced spouses. See Section 10.

What happens if I remarry? Is my former spouse still eligible for coverage?
If you remarry and your divorce judgment requires the continuance of health care coverage after your remarriage, your former spouse may continue coverage under an individual policy with a separate premium for that policy. Coverage ends if your former spouse remarries. If your former spouse moves out of the HNE Service Area, he or she will no longer be eligible for Health New England coverage.

In addition, Federal law permits continuation of group health care coverage for divorced spouses. See Section 10.

SECTION 8 – HOW TO ENROLL AND WHEN COVERAGE BEGINS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- You may enroll within 31 days of first becoming eligible.
- You may enroll during the annual Open Enrollment Period.
- The Group Insurance Commission sets your Effective Date of coverage.
- HNE will not provide any coverage before the set Effective Date.
- There are special rules for late enrollments.

Who can enroll?
Eligible employees and retirees and their eligible Dependents can enroll in the Plan. Retired state employees who are eligible for, and enrolled in, Medicare Part A & Part B, may not enroll in this plan. Please see Health New England's Member Handbook for Group Insurance Commission Medicare Enrolled Retirees.

When can a Subscriber enroll?
A Subscriber can enroll in the Plan on the first day of the month following 60 days of employment or two calendar months, whichever is less, or during the Open Enrollment Period.

Are there any times when I can enroll outside the above time period?
Yes. Under the Health Insurance Portability and Accountability Act (HIPAA), if you did not enroll in the Plan when first eligible, you will be allowed to enroll yourself and your eligible Dependents at a later date if any of the below conditions are met:

- You did not enroll in HNE because you, your spouse, or an eligible Dependent had COBRA continuation coverage under another plan when you otherwise became eligible to enroll in HNE, and that coverage has since been "exhausted."
- You did not enroll in HNE because you, your spouse, or an eligible Dependent had other insurance coverage when you otherwise became eligible to enroll in HNE, and you subsequently lost your eligibility for coverage, or employer contributions toward such coverage were terminated, as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.
- If you marry.
- If you acquire a new Dependent through birth, adoption, or placement for adoption.

If you meet any of the above conditions, you must make a written request for enrollment to the Group Insurance Commission within 31 days of the date of the event that qualifies you for coverage. Your coverage with HNE will be effective as of the date of the Qualifying Event.

What happens if I am already enrolled but then marry or acquire a new Dependent?
If you marry or acquire a new Dependent, you may add your new Dependent to the Plan. You must notify the Group Insurance Commission within 31 days of the following events:

- Marriage.
- Birth.
- Adoption or placement for adoption.
- Legal guardianship.
- The Subscriber becoming legally responsible for the Dependent's health care coverage.

How do I enroll?
To enroll in HNE you must meet the eligibility requirements of Section 7. You must also submit the following to your Group Insurance Commission Coordinator at your work site if you are an active employee, or directly to the Group Insurance Commission if you are a retiree, within 31 days of the requested Effective Date of coverage:

- A completed and signed Group Insurance Commission Enrollment/Change Form, and
- Any other forms or information that HNE may request.

What happens if I am pregnant, have a procedure or visit already scheduled, or have a chronic condition?
Please contact our Health Services Department. A nurse clinical liaison will talk with you about the transition of your care. *This is especially important if you are seeing a provider who is not an In-Plan Provider. You should also read the "Continued Treatment (Transitional Care)" provisions in Section 15.*

SECTION 9 – TERMINATION

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- You may end your coverage at any time.
- HNE may end your coverage for certain specified reasons.
- Your employer may end your coverage.
- If you lose your coverage, you may have the right to continue coverage under the Federal COBRA law or in HNE's nongroup plan.

HOW THIS AGREEMENT MAY END

HNE may cancel your coverage or refuse to renew your coverage only in the following circumstances:

1. The Commonwealth's agreement with Health New England ends and is not renewed.

2. You commit an act of physical or verbal abuse that poses a threat to providers or other HNE Members and that is unrelated to your physical or mental condition. At HNE's option, the effective date of termination may be any day after the date of the abuse.

3. You relocate outside the HNE Service Area.

What rights do I have when HNE ends my coverage?

HNE will provide for continuation of benefits to the full extent required under the law. See Section 10, "Continuation of Coverage Options." In addition, HNE will cooperate with the Group to facilitate the availability of continued coverage as required under federal and state laws.

SECTION 10 – CONTINUATION OF COVERAGE OPTIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- If you lose your coverage, you may have the right to continue your coverage.

SURVIVORS

In the case of the death of an employee or retiree, the surviving spouse may continue health plan coverage until remarriage. The surviving spouse must apply to the Group Insurance Commission for this service within 60 days of the date of the employee or retiree's death.

In the case of the death of a single or divorced employee or retiree, or the surviving spouse of a deceased employee or retiree, Dependent children may continue coverage through this program until age 19 or until they become eligible for other group health coverage, whichever is earlier. Application for continued coverage must be made within 60 days of the death of the insured parent.

CONTINUATION COVERAGE UNDER FEDERAL LAW (COBRA)

Under the federal law called COBRA (which stands for the Consolidated Omnibus Budget Reconciliation Act), if you lose Group health insurance coverage, you may have the right to continue coverage for up to 18 months for employees, or 36 months for Dependents, at your own expense. In general, you can continue coverage if you lose coverage for any of these reasons:

- The Subscriber leaves employment (except for gross misconduct), is laid off, or has his or her hours reduced.
- A Spouse gets divorced from the Subscriber.
- A child Dependent reaches age 19 or marries.
- A student Dependent is no longer a full-time student or marries.
- The Subscriber dies.

Federal law determines the amount Members pay for coverage and the length of the continuation coverage. For more detailed information about your rights under COBRA, see Appendix A. You must notify the Group Insurance Commission within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later.

CONTINUATION COVERAGE FOR DIVORCED SPOUSES UNDER STATE LAW

Massachusetts law gives Members the right to continue health coverage if they lose their eligibility for coverage following a Divorce. The divorced spouse can also continue coverage under the COBRA law described in "Continuation Coverage under Federal Law," or he or she can convert to nongroup coverage.

CONVERSION TO GUARANTEED ISSUE NONGROUP COVERAGE

Group Subscribers and Dependents who are no longer eligible for Group coverage may be eligible to continue coverage by enrolling in, and paying for, HNE's Guaranteed Issue Nongroup Plan. Call HNE for more information.

SECTION 11 – MEMBERS' RIGHTS AND RESPONSIBILITIES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- As a Member of HNE, you have certain rights and responsibilities.

MEMBERS' RIGHTS

As a Member of HNE, you have the right to:

- Receive information on HNE, its services, In-Plan Providers, policies, procedures, and your rights and responsibilities. HNE will not release information that by law may not be given to Members or any third party. We will not disclose privileged information about In-Plan Providers.
- Be treated with respect and recognition of your dignity and right to privacy.
- Participate with your physician or other health care provider in decisions regarding your health care.
- Expect that your physician or other health care provider will fully and candidly discuss appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage. However, this does not mean that all treatment options are necessarily covered by HNE. If you are unsure about whether a particular treatment is covered, you should contact HNE Member Services.
- Bring grievances and complaints about HNE or care provided by an In-Plan Provider to the attention of HNE, as outlined in our grievance process (see Section 6).
- Refuse treatment, drugs, or other procedures recommended by your physician or other health care provider to the extent permitted by law and to be informed of the potential medical consequences of refusing treatment.
- Select, from HNE's Provider Directory, a Primary Care Physician (PCP) who is accepting new patients.
- Request to change your PCP, as long as the newly chosen PCP has not notified HNE that he or she no longer accepts new patients.
- Have access, during HNE's business hours, to HNE Member Services representatives who can answer questions and assist in resolving problems.
- Expect that information from your medical records and information about your doctor/patient and hospital/patient relationships will be kept confidential in accordance with state and federal law and as provided by HNE policies and rules.
- Make recommendations regarding HNE's Member rights and responsibilities policies.

MEMBERS' RESPONSIBILITIES

As a Member of HNE, you have the responsibility to:

- Provide, to the extent possible, information to your providers that they need in order to care for you. This includes giving your providers information about your present and past medical conditions, as you understand them, before and during any course of treatment.

- Follow the plans and instructions for care that you have agreed on with your provider.
- Familiarize yourself with your HNE benefits and services by reading materials distributed by HNE and by calling HNE Member Services with any questions.
- Abide by all HNE policies and procedures.
- Treat In-Plan Providers and HNE staff with the same respect and courtesy you expect for yourself.
- Arrive on time for scheduled appointments or give adequate notice if you must cancel or will be late.
- Understand your health problems. If you do not understand your illness or treatment, talk it over with your physician. Understanding your health problems is important to the success of the treatment.
- Participate in decision-making regarding your health care.
- Inform HNE of any other insurance coverage you have so HNE may appropriately administer claims payment and coordinate with other payors.
- Inform HNE of any changes in status that could affect your eligibility for coverage, such as a change of address.
- Assist HNE and In-Plan Providers in obtaining prior medical records when asked to do so. You agree that HNE may obtain and use any of your medical records and other information required to administer the Plan.
- Consider the potential effects if you do not follow your provider's advice. When a service recommended by an In-Plan Doctor is covered, you may choose to decline it for personal reasons. For example, you may prefer to get care from Out-of-Plan Providers rather than In-Plan Providers. In these cases, HNE may not cover substitute or alternate care that you prefer.

SECTION 12 – COORDINATION OF BENEFITS AND SUBROGATION

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- HNE has certain coordination of benefits, reimbursement and "subrogation" rights that are explained in this Section.
- You must cooperate with us and give us the information that we need to coordinate benefits or subrogate a claim.

At times, HNE provides coverage for benefits and services under this Member Handbook when it is the duty of another plan to pay. If this happens, HNE has the right to recover from a Member's other insurance the value of the services that were provided or arranged by HNE's In-Plan Providers. Also, whenever payments which should have been made by HNE in accordance with this section have been made by any other plan, HNE will have the right, at its discretion, to pay that plan any amount it determines to be warranted. The amounts paid will be considered benefits that HNE paid. HNE will be fully released from liability under this Member Handbook to the extent of such payments.

For the purposes of this section, HNE may give or obtain any information about a Member that it deems necessary. Any Member claiming benefits under this Member Handbook must provide HNE with the information it needs to carry out this section.

Benefits under this Member Handbook will be coordinated to the extent permitted by law with other plans covering health benefits, including: all health benefit plans, governmental benefits (including Medicare), motor vehicle insurance, medical payment policies, and homeowner insurance.

HNE's rights under this section will remain even after this Member Handbook ends, but only as to services provided while the Member Handbook was in effect.

COORDINATION OF BENEFITS

What happens if I have other group health insurance?
When anyone has coverage with HNE and another Group health plan, it is known as "double coverage." You must tell us if you or a family member has double coverage. You must also send us documents about your other insurance if we ask for them. When you have double coverage, one plan is the primary payor; it pays benefits first. The other plan is secondary. It pays benefits next. This process is known as "coordination of benefits." If we are the secondary payor, we may be entitled to receive payment from your primary plan. HNE decides which insurance is primary based on rules used throughout the insurance industry, or as required by state laws and applicable regulations. A copy of these rules is available upon request.

We will always provide you with the benefits described in this Member Handbook. However, HNE will only provide coverage under this Member Handbook to Members who have other health insurance coverage if they follow HNE policies and rules. For example, if you see certain In-Plan Specialists without an HNE referral, HNE will not cover the services you receive.

What happens if I or one of my Dependents is enrolled in Medicare?
You must tell us and the Group Insurance Commission if you or a family member is enrolled in Medicare Part A or B. Medicare rules determine who has the first responsibility to pay for medical care. When HNE provides benefits to a Medicare eligible Member, HNE will coordinate coverage with Medicare according to Medicare rules.

What happens if I am entitled to benefits under another medical payment policy?
For Members who are injured and therefore entitled to benefits under the medical payment benefit of any other insurance policy, such as a homeowner's or auto insurance policy, such coverage will be primary to the coverage under this Member Handbook. When HNE provides benefits to a Member that the Member is eligible for under such other medical payment policy, HNE will coordinate coverage with the other carrier. If the other coverage entitles you to be directly reimbursed for certain medical expenses, you agree to allow the payment to be made directly to HNE.

What happens if I am injured at work? Will HNE pay for the services that I receive?
If HNE has information showing that services provided to a Member are covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state, or other government agency, HNE may suspend payment for such services until a determination is made whether payment will be made by such program. If HNE provides or pays for services for an illness or injury covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state, or other government agency, HNE will be entitled to recover its expenses from the provider of services or the party or parties legally obligated to pay for such services.

SUBROGATION

As an HNE Member, you agree to give HNE a right of subrogation and a right of reimbursement. These terms are explained in this section.

Who pays my medical bills if another party is responsible for my injuries or illness?
Occasionally, HNE pays medical bills for which another person (or his or her insurer) is legally responsible. HNE then has the right to make a claim against the third party to recover for the benefits and services provided. This is called subrogation.

For example, if you are in an accident and another party is liable for your injuries, HNE will file a lien to recover the provider's charges (i.e., the billed amount) for any benefits provided to you under this Member Handbook. HNE has a right to recover even if you do not receive full settlement. HNE's recovery is limited, however, to the amount you received by suit or settlement.

HNE also has the right to sue in your name at its expense. If a suit brought by HNE results in an award greater than the provider's charges, HNE then has the right to recover costs of the suit and attorney's fees out of the excess.

What if I have already received payment for my injuries?
If you receive payment from another party for injuries caused by the acts or omissions of a third party, HNE has a right of reimbursement. The right of reimbursement arises only after you receive payment for your injuries from a third party or that party's insurer. HNE then has the right to request reimbursement for the benefits and services provided to you.

If you receive payment from a third party, HNE will seek reimbursement from you for the provider's charges for the benefits and services provided to you. HNE's right to reimbursement applies even if you did not receive full settlement for your injuries. HNE will not ask for more than you received by suit or settlement.

What are my responsibilities as a Member when HNE decides to subrogate?
As a Member, it is your duty to cooperate with HNE and provide HNE with any documents and information needed to help HNE receive its repayment. You must not do anything to hinder or prevent HNE from pursuing this recovery. If you have a lawyer, you must ask him or her to cooperate as well. If you fail to cooperate or provide requested assistance, you may be liable for any expenses incurred by HNE, including reasonable attorney fees, in enforcing its rights under this Member Handbook.

SECTION 13 – OTHER PLAN ADMINISTRATION PROVISIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- HNE and its Providers are independent contractors.
- HNE may amend this Member Handbook at any time.

Amendments
This Member Handbook is effective as of July 1, 2004. If you would like to know if HNE has made any changes to this Member Handbook, please call HNE Member Services.

HNE, with the agreement of the Group Insurance Commission, may amend this Member Handbook at any time if the amendments: (1) are not in violation of any law; (2) comply with applicable rules and regulations of the Massachusetts Division of Insurance; or (3) are required by any state or federal law, regulation, or rule. These changes will apply to all agreements of this type, not just to this Member Handbook. These changes will be effective whether or not an individual Member in fact receives notice of the amendment. Changes will apply to all benefits or services provided after the Effective Date of the change.

Contracting Parties
Nothing in this Member Handbook will create or is meant to create any relationship between the parties other than that of independent contracting parties. The Group and HNE are independent entities, and neither party is the partner, agent, employee, or servant of the other.

Members and Other Third Parties
Except as specifically provided in this Member Handbook, this Member Handbook will not create any rights in a Member or any other person as a third party beneficiary of this Member Handbook.

Health New England and Providers
The relationship between HNE and its In-Plan Providers is a direct or indirect independent contractor relationship. As such, each party is at all times acting and performing as an independent contractor, and neither party will have or exercise any control or discretion over the method by which the other party shall perform such work or render or perform such services or functions. It is further expressly understood that no work, act, commission, or omission of any party, its employees, agents, or servants will be construed to make or render any party, its employees, agents or servants an employee, agent, servant, representative or joint venturer with, the other party.

Payment of Providers
HNE pays In-Plan Providers in a number of ways. For example, we may pay a set fee for each *service*, each *day* (of a hospital stay), or each *case*. We also may pay a set amount each month for each Member signed up with a provider or group of providers, regardless of whether the Member is actually treated. (This payment is called a *capitation* payment.) In many cases, HNE assigns providers to a grouping or "pool" of providers. In these cases, HNE puts a part of each payment to the provider into his/her pool until the end of the year. If the pool meets set goals or targets, HNE will pay some or the entire amount put aside, or the full amount plus a bonus. HNE does not base payments or bonuses on denials or coverage of services.

Members and Providers
The relationship of a Member to a provider is based solely on the provider-patient relationship. Each provider is solely responsible for all health care services furnished to a Member.

Agreement Binding on Members
By enrolling in the Plan, or receiving benefits or coverage under the Plan, you agree to all terms and conditions of this Member Handbook. Subscribers will be responsible for their Dependents' compliance with this Member Handbook. Minor Dependents of Subscribers will be bound by the actions of the Subscriber.

Waiver
No waiver occurs if HNE fails to enforce any provision of this Member Handbook. HNE may enforce the provision at a future date. Similarly, no waiver occurs if HNE fails to enforce any remedy arising from a default under the terms of this Member Handbook.

Severability
If any part of this Member Handbook is declared not enforceable or not valid, such invalidity or unenforceability will not affect any other section or clause of this Member Handbook. The remaining sections or clauses of this Member Handbook will remain in full force and effect.

Governing Law
This Agreement will be governed and construed according to the laws of the Commonwealth of Massachusetts.

Conformance with Law
Each party agrees to carry out all activities that are taken pursuant to this Member Handbook in conformance with all applicable federal and state laws, regulations, rules, and policies.

Notices
Any notice under this Member Handbook may be given by United States mail, postage prepaid, addressed as follows:

To HNE:	President and Chief Executive Officer Health New England, Inc. One Monarch Place Springfield, MA 01144-1500
To a Subscriber/Member:	To the latest address on file with HNE
To the Group:	Group Insurance Commission P.O. Box 8747 Boston, MA 02114-8747

Circumstances Beyond HNE's Control
HNE will try to arrange for services in the case of major disasters. However, HNE will not be liable for any failure to provide or arrange, or for delay in providing or arranging, services or supplies in the event of any of the following: natural disaster, war, riot, civil insurrection, strikes, epidemic, or any other Emergency or event caused by an act which is beyond the control of HNE.

SECTION 14 – NOTICE OF PRIVACY PRACTICES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

HNE knows how important it is to protect your privacy at all times and in all settings. This Notice of Privacy Practices describes how Health New England ("HNE") may collect, use and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

State and federal law require us to maintain the privacy of your protected health information. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) also requires us to provide you this notice about our legal duties and privacy practices. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace or modify it. We may change the terms of this notice at any time. The new notice will be effective for all protected health information that we maintain. We will mail a new Notice of Privacy Practices whenever we make a material change to the privacy practices described in this notice.

How does HNE protect my personal health information?
HNE has a detailed policy on confidentiality. All HNE employees are required to protect the confidentiality of your PHI. An employee may only access your information when they have an appropriate reason to do so. Each employee or temporary employee must sign a statement that he or she has read and understands the policy. On an annual basis, HNE will send a notice to employees to remind them of this policy. Any employee who violates the policy is subject to discipline, up to and including dismissal. If you would like a copy of HNE's Privacy Policy, you may request a copy from HNE Member Services. In addition, HNE includes confidentiality provisions in all of its contracts with In-Plan Providers. HNE also maintains physical, electronic, and procedural safeguards to protect your information.

How does HNE collect protected health information?
HNE gets PHI from:

- Information we receive directly or indirectly from you, your employer or benefits plan sponsor through applications, surveys, or other forms. For example, name, address, social security number, date of birth, marital status, Dependent information, employment information and medical history.
- Providers who are treating you or who are involved in your treatment and/or their staff when they submit claims or request authorization on your behalf for certain services or procedures.
- Attorneys who are representing our Members in automobile accidents or other cases.
- Insurers and other health plans.

How does HNE use and disclose my protected health information?
HIPAA and other laws allow or require us to use or disclose your PHI for many different reasons. We can use or disclose your PHI for some reasons without your written agreement. For other reasons, we need you to agree in writing that we can use or disclose your PHI.

Uses and Disclosures for Treatment, Payment and Health Care Operations. HNE uses and discloses protected health information in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. We can also disclose your information to providers and other health plans that have a relationship with you, for *their* treatment, payment and some limited health care operations. The following are only a few examples of the types of uses and disclosures of your protected health information that we are permitted to make *without* your authorization for these purposes:

Treatment: We may disclose your protected health information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. We may also disclose your protected health information to health care providers (including their employees or business associates) in connection with preventive health, early detection and disease and case management programs.

Payment: We will use and disclose your protected health information to administer your health benefits policy or contract, which may involve:

- Determining your eligibility for benefits;
- Paying claims for services you receive;
- Making medical necessity determinations;
- Coordinating your care, benefits or other services;
- Coordinating your HNE coverage with that of other plans (if you have coverage through more than one plan), to make sure that the services are not paid twice;
- Responding to complaints, appeals and external review requests;
- Obtaining premiums, underwriting, ratemaking and determining cost sharing amounts; and
- Disclosing information to providers for their payment purposes.

Health Care Operations: We will use and disclose your protected health information to support HNE's other business activities, including the following:

- Conducting quality assessment activities, or for the quality assessment activities of providers and other health plans that have a relationship with you;
- Developing clinical guidelines;
- Reviewing the competence or qualifications of providers that treat our Members;
- Evaluating our providers' performance as well as our own performance;
- Obtaining accreditation by independent organizations such as the National Committee for Quality Assurance;
- Maintaining state licenses and accreditations;
- Conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs;
- Business planning and development, including the development of HNE's drug Formulary;
- Operation of preventive health, early detection and disease and case management and coordination of care programs, including contacting you or your doctors to provide appointment reminders or information about treatment alternatives, therapies, health care providers, settings of care or other health-related benefits and services;
- Reinsurance activities; and
- Other general administrative activities, including data and information systems management and customer service.

Other Permitted or Required Uses and Disclosures of Protected Health Information. In addition to treatment, payment and health care operations, federal law allows or requires us to use or disclose your protected health information in the following additional situations without your authorization:

Required by Law: We may use or disclose your protected health information to the extent we are required to do so by state or federal law. For example, the HIPAA law compels us to disclose PHI when required by the Secretary of the Department of Health and Human Services to investigate our compliance efforts.

Public Health Activities: We may disclose your protected health information to an authorized public health authority for purposes of public health activities. The information may be disclosed for such reasons as controlling disease, injury or disability. We also may have to disclose your PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading the disease. In addition, we may make disclosures to a person subject to the jurisdiction of the Food and Drug Administration, for the purpose of activities related to the quality, safety or effectiveness of an FDA-regulated product or activity.

Abuse or Neglect*:* We may make disclosures to government authorities if we believe you have been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when we are required or authorized by law to do so.

Health Oversight: We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs, or its contractors (e.g., state insurance department, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activity.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your protected health information under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Coroners, Funeral Directors and Organ Donation: We may disclose your protected health information in certain instances to coroners, funeral directors and organizations that help find organs, eyes, and tissue to be donated or transplanted.

Threat to Health or Safety: If we believe that a serious threat exists to your health or safety, or to the health and safety of any other person or the public, we will notify those persons we believe would be able to help prevent or reduce the threat.

Military Activity and National Security: We may disclose your protected health information to Armed Forces personnel under certain circumstances and to authorized federal officials for the conduct of national security and intelligence activities.

Correctional Institutions: If you are an inmate in a correctional facility, we may disclose your protected health information to the correctional facility for certain purposes, including the provision of health care to you or the health and safety of you or others.

Workers' Compensation: We may disclose your protected health information to the extent required by workers' compensation laws.

Will HNE give my PHI to my family or friends?
We will only disclose your PHI to a member of your family (including your spouse), a relative, or a close friend in the following circumstances:

- You have authorized us to do.
- That person has submitted proof of legal authority to act on your behalf.
- That person is involved in your health care or payment for your health care and needs your PHI for these purposes. If you are present for such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it. We will only release the PHI that is directly relevant to their involvement.
- We may share your PHI with your friends or family members if professional judgment says that doing so is in your best interest. We will only do this if you are not present or you are unable to make health care decisions for yourself. For example, if you are unconscious and a friend is with you, we may share your PHI with your friend so you can receive care.
- We may disclose a minor child's PHI to their parent or guardian. However, we may be required to deny a parent's access to a minor's PHI, for example, if the minor is an emancipated minor or can, under law, consent to their own health care treatment.

Will HNE disclose my personal health information to anyone outside of HNE?
HNE may share your protected health information with affiliates and third party "business associates" that perform various activities for us or on our behalf. For example, HNE may delegate certain functions, such as medical management or claims repricing, to a third party that is not affiliated with HNE. HNE may also share your personal health information with an individual or company that is working as a contractor or consultant for HNE. HNE's financial auditors may review claims or other confidential data in connection with their services. A contractor or consultant may have access to such data when they repair or maintain HNE's computer systems. Whenever such an arrangement involves the use or disclosure of your protected health information, we will have a written contract that contains terms designed to protect the privacy of your protected health information.

HNE may also disclose information about you to your Primary Care Physician, other providers that treat you and other health plans that have a relationship with you, for their treatment, payment and some of their health care operations.

Will HNE disclose my personal health information to my employer?
In general, HNE will only release to your employer enrollment and disenrollment information, information that has been de-identified so that your employer can not identify you or summary health information. If your employer would like more specific PHI about you to perform plan administration functions, we will either get your written permission or we will ask your employer to certify that they have established procedures in their group health plan for protecting your PHI, and they agree that they will not use or disclose the information for employment-related actions and decisions. Contact your employer to get more details.

When does HNE need my written authorization to use or disclose my personal health information?
We have described in the preceding paragraphs those uses and disclosures of your information that we may make either as permitted or required by law or otherwise without your written authorization. For other uses and disclosures of your medical information, we must obtain your written authorization. Among other things, a written authorization request will specify the purpose of the requested disclosure, the persons or class of persons to whom the information may be given, and an expiration date for the authorization. If you do provide a written authorization, you generally have the right to revoke it.

Many Members ask us to disclose their protected health information to third parties for reasons not described in this notice. For example, elderly Members often ask us to make their records available to caregivers. To authorize us to disclose any of your protected health information to a person or organization for reasons other than those described in this notice, please call our Member Services Department and ask for an Authorization and Designation of Personal Representative Form. You should return the completed form to HNE's Enrollment Department at One

Monarch Place, Springfield, MA 01144-1500. You may revoke the authorization at any time by sending us a letter to the same address. Please include your name, address, Member identification number and a telephone number where we can reach you.

What are my rights with respect to my PHI?
The following is a brief statement of your rights with respect to your protected health information:

Right to Request Restrictions: You have the right to ask us to place restrictions on the way we use or disclose your protected health information for treatment, payment or health care operations or to others involved in your health care. **However, we are not required to agree to these restrictions.** If we do agree to a restriction, we may not use or disclose your protected health information in violation of that restriction, unless it is needed for an Emergency.

Right to Request Confidential Communications: You have the right to request to receive communications of protected health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you. We will accommodate reasonable requests. Your request must be in writing.

Right to Access Your Protected Health Information: You have the right to see and get a copy of the protected health information about you that is contained in a "designated record set," with some specified exceptions. Your "designated record set" includes enrollment, payment, claims adjudication, case or medical management records and any other records that we use to make decisions about you. Requests for access to copies of your records must be in writing and sent to the attention of the HNE Legal Department. Please provide us with the specific information we need to fulfill your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.

Right to Amend Your Protected Health Information: You have the right to ask us to amend any protected health information about you that is contained in a "designated record set" (see above). All requests for amendment must be in writing and on an HNE Request for Amendment form. Please contact the HNE Legal Department to obtain a copy of the form. You also must provide a reason to support the requested amendment. In certain cases, we may deny your request. For example, we may deny a request if we did not create the information, as is often the case for medical information in our records. All denials will be made in writing. You may respond by filing a written statement of disagreement with us, and we would have the right to rebut that statement. If you believe someone has received the unamended protected health information from us, you should inform us at the time of the request if you want them to be informed of the amendment.

Right to Request an Accounting of Certain Disclosures: You have the right to have us provide you an accounting of times when we have disclosed your protected health information for any purpose other than the following:

(i) treatment, payment or health care operations;
(ii) disclosures to others involved in your health care;
(iii) disclosures that you or your personal representative have authorized; or
(iv) certain other disclosures, such as disclosures for national security purposes.

All requests for an accounting must be in writing. We will require you to provide us the specific information we need to fulfill your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee.

Right to Request a Copy of this Notice: If you have received this notice electronically, you have the right to obtain a paper copy of this notice upon request.

Who should I contact if I have a question about this notice or a complaint about how HNE is using my personal health information?

Complaints and Communications With Us. If you want to exercise your rights under this Notice, communicate with us about privacy issues, or if you wish to file a complaint with us, you can write to:

Health New England, Inc.
Complaints and Appeals Department
One Monarch Place
Springfield, MA 01144-1500

You can also call us at 800-310-2835 or 413-787-4004. You will not be retaliated against for filing a complaint with us.

Complaints to the Federal Government. If you believe your privacy rights have been violated, you also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint with the federal government.

SECTION 15 – DISCLOSURES REQUIRED BY LAW

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- This section contains information which the law requires HNE to disclose to its Members.

Quality Management Program
The HNE Quality Management Program is developed annually to address the quality and safety of clinical care and the quality of services provided to the Plan's Members. The written program description defines our quality management program structure, objectives, processes, and resources used to identify, review, measure, monitor, and evaluate the activities implemented by HNE to meet the goals of the program.

HNE also develops a Quality Management Work Plan annually. This is the listing of activities that are implemented to meet our program goals. Projects focusing on patient safety, behavioral health issues, utilization of services, Member and provider communications, confidentiality, disease management, prevention, and continuity of care for Members have been implemented. The time frame for completion of each project is very different. Some are very simple, can be completed in a matter of months, while others are ongoing, and will be followed by HNE throughout the year.

The Plan's Board of Directors has made the Quality Management Committee responsible for the performance of the Plan. The HNE Quality Management Committee meets about six times a year to review and monitor the progress of the activities listed in the Work Plan. Participation by individual HNE network providers is also essential to the functioning of the Quality Management Program.

If you would like any information regarding the HNE Quality Management Program Description or Work Plan, please contact the Quality Operations Manager at 413-233-3435. HNE will provide this information on request.

Summary Description of Process for Developing Clinical Guidelines and Utilization Review Criteria
HNE has a written program for how health care service and delivery are reviewed. The program is made up of activities in the areas of utilization, case, and disease management. Its purpose is to help Members to receive the appropriate care. HNE may conduct reviews before or during the delivery of services. HNE uses nationally recognized guidelines and resources for these reviews. HNE also uses criteria that it develops with the input of local practicing physicians. Physicians outside the HNE staff may be consulted to help make a decision of medical appropriateness. Non-physicians can make a decision to approve care or services. Only HNE Medical Directors can make a decision to deny coverage for reasons of medical necessity. At times, HNE may delegate certain utilization management functions to other entities. When this occurs, HNE requires the entity to use program procedures and criteria approved by HNE. HNE annually reviews its utilization review program.

Summary Description of HNE's Procedures in Making Decisions about the Experimental or Investigational Nature of Individual Drugs, Medical Devices, or Treatments in Clinical Trials
HNE has several programs to address this area. In general, the decision process is as follows:

- HNE uses Hayes, Inc. to research new and emerging medical technologies. Hayes also researches new uses of existing technologies. The research is structured and evidence-based. Analyses of market, regulatory, legal, ethical, and actuarial issues are part of the study. Hayes then makes coverage recommendations to HNE.
- To evaluate drugs, HNE uses Express Scripts®, Inc. Express Scripts® uses a committee of physicians and pharmacists to review new FDA-approved drugs that have been available in the United States for at least six months. Some of the criteria used to evaluate drugs are:
    - Safety.

- The potential effects of treatment under optimal circumstances.
- The actual effects of treatment under real life conditions.
- Potential health outcomes and resulting total cost of drugs and medical care, and potential savings available.
- Any restrictions needed to assure safe, effective, or proper use of the drug, patient outcome, or cost effectiveness.

- The recommendations by Hayes and Express Scripts® are then screened by an internal HNE committee. If more medical input is needed, an In-Plan physician will be consulted. He or she will provide a written opinion to HNE.
- The findings are then reported to another HNE committee, which includes In-Plan physicians, for discussion at its next meeting. This allows for local practicing physician input.
- Recommendations will then go to the HNE Medical Policy Committee for final decision. The committee makes a decision based on its review of the recommendations and other HNE-specific data, such as:
  - Prevalence of disease(s) associated with proposed technologies.
  - Benefits to HNE Members.
  - Cost.
  - Use of current technologies and projected use of new technology.

HNE does not cover any experimental or investigational device or treatment unless it has been reviewed and approved by HNE's Medical Technology Assessment Committee.

Continued Treatment (Transitional Care)

Provider disenrollment and continuation of coverage requirements:

There are times when HNE will allow you to continue to receive coverage for care after your doctor disenrolls. Those circumstances are:

- If your PCP disenrolls. HNE will notify you at least 30 days before the disenrollment of your PCP. HNE will permit you to continue to see your PCP for a period of 30 days after your PCP is disenrolled. HNE will also allow a Member who is in active treatment for a chronic or acute condition to continue to see his or her PCP through the current period of active treatment or up to 90 days after the PCP is disenrolled, whichever is shorter. You will not be allowed to continue to see your PCP if your PCP is disenrolled for reasons related to quality or for fraud. If your PCP is disenrolled, HNE will send you a letter to notify you and to advise you to call HNE to select a new PCP. If you do not select a new PCP, HNE will assign one to you.
- If your specialist disenrolls. HNE will notify you at least 30 days before the disenrollment. HNE will help you to select a new specialist if you would like. HNE will let a Member who is in active treatment for a chronic or acute condition to continue to see the specialist through the current period of active treatment or for up to 90 days after the specialist is disenrolled, whichever is shorter. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons relating to quality or for fraud.
- If a provider who is treating pregnant Members is involuntarily disenrolled. If this occurs and you are in your second or third trimester of pregnancy, HNE will permit you to continue treatment with your provider through the postpartum period. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons related to quality or for fraud.
- If a provider who is treating terminally ill Members is involuntarily disenrolled. If this occurs and you are terminally ill, HNE will permit you to continue treatment with your provider until your death. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons related to quality or for fraud.

Transitional coverage for new Members:

HNE will provide coverage for a new Member to continue to see an Out-of-Plan Provider for up to thirty 30 days from the Effective Date of coverage if:

- The Member's employer only offers the Member a choice of carriers in which the physician is not a participating provider, and
- The physician is providing the Member with an ongoing course of treatment or is the Member's PCP.

With respect to an insured in her second or third trimester of pregnancy, this provision will apply to services rendered through the postpartum period. With respect to an insured with a terminal illness, this provision will apply to services rendered until death.

Requirements for transitional coverage:
In all of the above circumstances, HNE will only permit a Member to continue coverage if their provider agrees:

- To accept payment from HNE at the rates applicable to participating providers or at the rates considered payment in full prior to the notice of disenrollment.
- Not to require the Member to be responsible for cost sharing that exceeds the amount that could have been required if the provider participated with HNE or if the provider had not been disenrolled.
- To adhere to HNE's quality assurance standards and to provide HNE with necessary medical information related to the care provided.
- To adhere to HNE's policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by HNE.

Nothing in this section will be construed to require the coverage of benefits that would not have been covered if the provider involved remained an In-Plan Provider.

Premium Rates and Payment Arrangements (Prepaid Fees)
With HNE, your employer pays a prepaid monthly fee ("premium") on your behalf for HNE benefits. The premium is due on or before the first day of the billing period to which it applies. The premium rates are shown in the Group Insurance Commission contract. The Commission must send HNE the premium due for each Subscriber.

The rates charged may change from year to year, or at other times, in accordance with the terms of the Group Insurance Commission contract. The Commission has the responsibility to notify its employees of the premium rate charge or of any changes in the charge. Any such change will take effect on the date specified in the Group Insurance Commission contract. If you would like to find out what the premium is for your coverage, please contact your Group Insurance Coordinator at your work site, or the Group Insurance Commission.

Pediatric Specialty Care
HNE will provide coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to Members requiring such services.

Physician Profiling Information
Physician profiling information, so called, is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts. You can request a physician printout by calling 800-377-0550.

HNE's Involuntary Disenrollment Rate
HNE's involuntary disenrollment rate is 0%.

SECTION 16 – DEFINITIONS

Adverse Determination – A decision, based upon a review of information provided, to deny, reduce, change, or end coverage of a health service for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Agreement – This Member Handbook, any amendments, and the Group Insurance Commission contract between your Group and HNE.

Calendar Year – The 12 month period beginning January 1 and ending December 31.

Copayment – The amount specified in this Member Handbook or any amendments to this Member Handbook that you are required to pay when receiving Covered Services.

Covered Services – Medically Necessary services and benefits to which you are entitled, as set forth in this Member Handbook.

Custodial Care – Custodial Care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, HNE considers the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

Dependent – Any person who meets the Dependent requirements of Section 7, who is enrolled, and for whom HNE has received the premium specified in the Group Insurance Commission contract.

Effective Date – The date on which coverage begins under this Member Handbook.

Emergency – A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Employer Group Agreement – An Agreement between your Group and HNE that details premium rates, Effective Date, and other obligations.

Formulary – A list of preferred brand name drugs offered to Members for a higher Copayment than generic drugs.

Group – The Commonwealth of Massachusetts Group Insurance Commission.

Hospital Services – Those Covered Services that are usually provided by acute care general hospitals in the Service Area and which are prescribed or approved by an In-Plan Doctor.

Identification Card (ID Card) – The card that HNE issues to a Subscriber upon enrollment and which must be presented at the time of service.

Infertility – The inability of an individual (or couple), who should expect fertility as a natural state, to conceive during a period of at least one year of attempting to conceive.

In-Plan Doctor – A licensed doctor or oral surgeon who has an existing agreement with HNE to provide certain Covered Services to Members. HNE and the In-Plan Doctor are independent entities, and neither party is the agent, employee, or servant of the other.

1. Primary Care Physician (PCP) – An In-Plan Doctor who has been designated by HNE to be primarily responsible for providing or arranging for Covered Services to Members.
2. In-Plan Specialist – An In-Plan Doctor who is eligible to provide a specialty service and who has agreed with HNE to provide such services.

In-Plan Hospital – A licensed acute care general hospital that has agreed with, and been designated by, HNE to provide Hospital Services. HNE and the In-Plan Hospital are independent entities, and neither party is the agent, employee, or servant of the other.

In-Plan Provider – Any hospital, doctor, health care facility, agency, organization, pharmacy, or person that is properly licensed or otherwise authorized to furnish health care services and which has agreed with HNE to provide Medically Necessary services to HNE Members. HNE and the In-Plan Provider are independent entities, and neither party is the agent, employee, or servant of the other.

In-Plan Specialty Referral Form – The HNE document that is completed and signed by an In-Plan Doctor to arrange for services with certain In-Plan Specialists. This referral must be presented to the provider before or at the time services are rendered.

Medically Necessary Services – Those Covered Services and supplies that HNE's Medical Director determines are (a) essential for the treatment of a Member's medical condition, (b) in accordance with generally accepted medical practice, and (c) provided at an appropriate facility and at the appropriate level of care for the treatment of a Member's medical condition in accordance with generally accepted standards in the medical community.

Member – Any person who is enrolled in HNE and has a right to services under this Member Handbook.

Non-Formulary – Any brand name drug that is not listed on the Formulary.

Open Enrollment Period – That period of each contract year when, by agreement between HNE and the Group, eligible persons may enroll or when Members may transfer from the Plan to an available alternate health benefits plan without any lapse in coverage.

Out-of-Plan Provider – Any licensed provider who is not an In-Plan Provider.

Prior Approval – The process by which HNE reviews and approves coverage for certain services before the services are performed.

Qualified Beneficiary – Persons who are covered under a Group health benefit plan on the day before a COBRA Qualifying Event.

Qualifying Event – A loss of coverage that would make a Qualified Beneficiary eligible to receive continuation coverage under COBRA.

Service Area – The area in which HNE is authorized to provide Covered Services to Members.

Subscriber – A person who meets the eligibility requirements of Section 7, who is enrolled, and for whom HNE has received the premium specified in the Group Insurance Commission contract.

APPENDIX A: GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

This notice contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's Health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "Qualifying Events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth ends (for any reason other than gross misconduct) or his/her hours of employment are reduced; or
- You and your spouse divorce or legally separate.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "Qualifying Events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced;
- The parents divorce or legally separate; or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to

employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other Qualifying Events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial Qualifying Event) if a second Qualifying Event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second Qualifying Event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial Qualifying Event) if any Qualified Beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another Qualified Beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the Qualified Beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A Qualified Beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first**

payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The GIC has no involvement in conversion programs, and you pay premiums to the health plan for the conversion coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

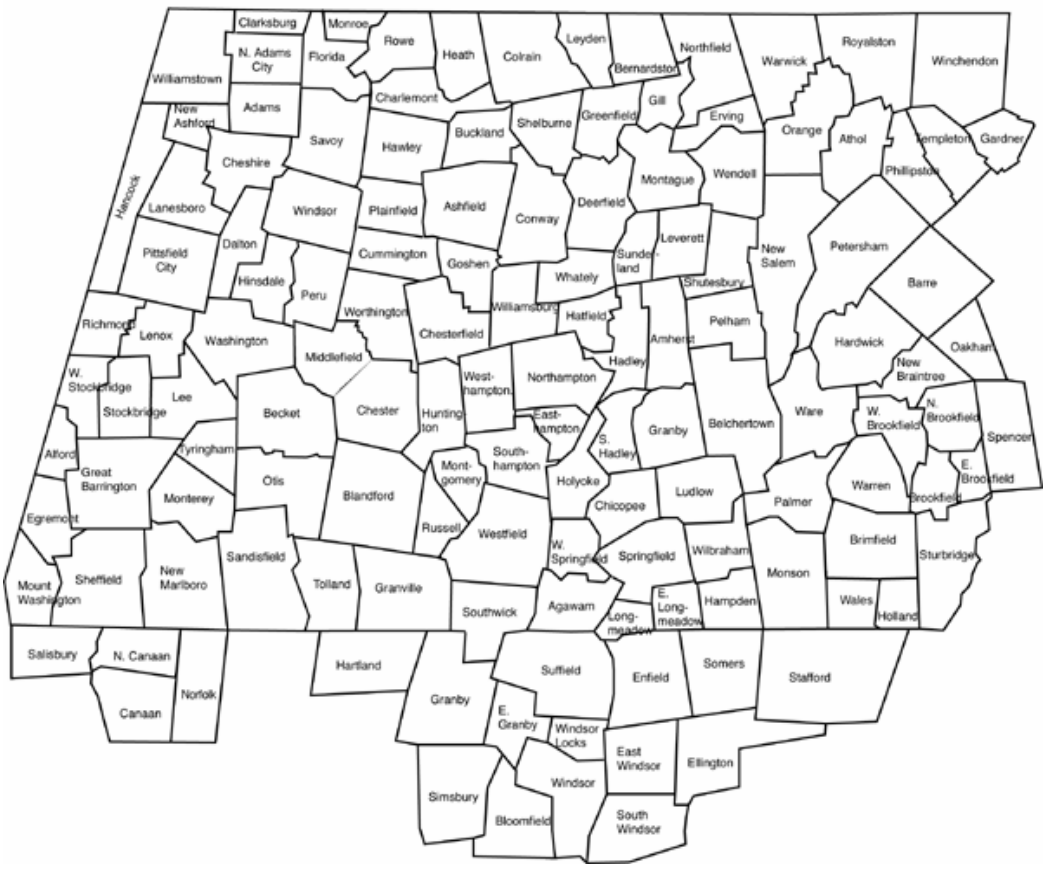
YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the Qualifying Events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The employee or former employee dies;
  - The employee divorces or legally separates;
  - The employee or employee's former spouse remarries;
  - A covered child ceases to be a dependent;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747.

Notes:

HEALTH NEW ENGLAND SERVICE AREA



Health New England®

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